

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10001				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10001	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ROSARIA SICA				2. DATE AND HOUR OF DEATH October 16, 1967 10:45 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md., B. COUNTY 21206 C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-01 Baltimore D. STREET ADDRESS (If rural, give location) 5504 Knell Ave.			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 10/5/1885	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Girdano				14. MOTHER'S MAIDEN NAME unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Frank Sica, son, 5504 Knell Ave., 6			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 51 to Oct 16 1967, that (I) (we) last saw the deceased alive on Oct 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Thomas L. Worsley</i> Dr. Thomas L. Worsley, Jr.				23B. DATE SIGNED 10/18/67		23C. PHYSICIAN'S NAME (Type)	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 10/20/67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.				25A. DATE REC'D BY HEALTH DEPT. OCT 20 1967			
25B. NAME OF REGISTRAR Robert E. Fairbairn				25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			

2. Robert. Charles. William. James.

21 - 10 - 17

20 - 10 - 17

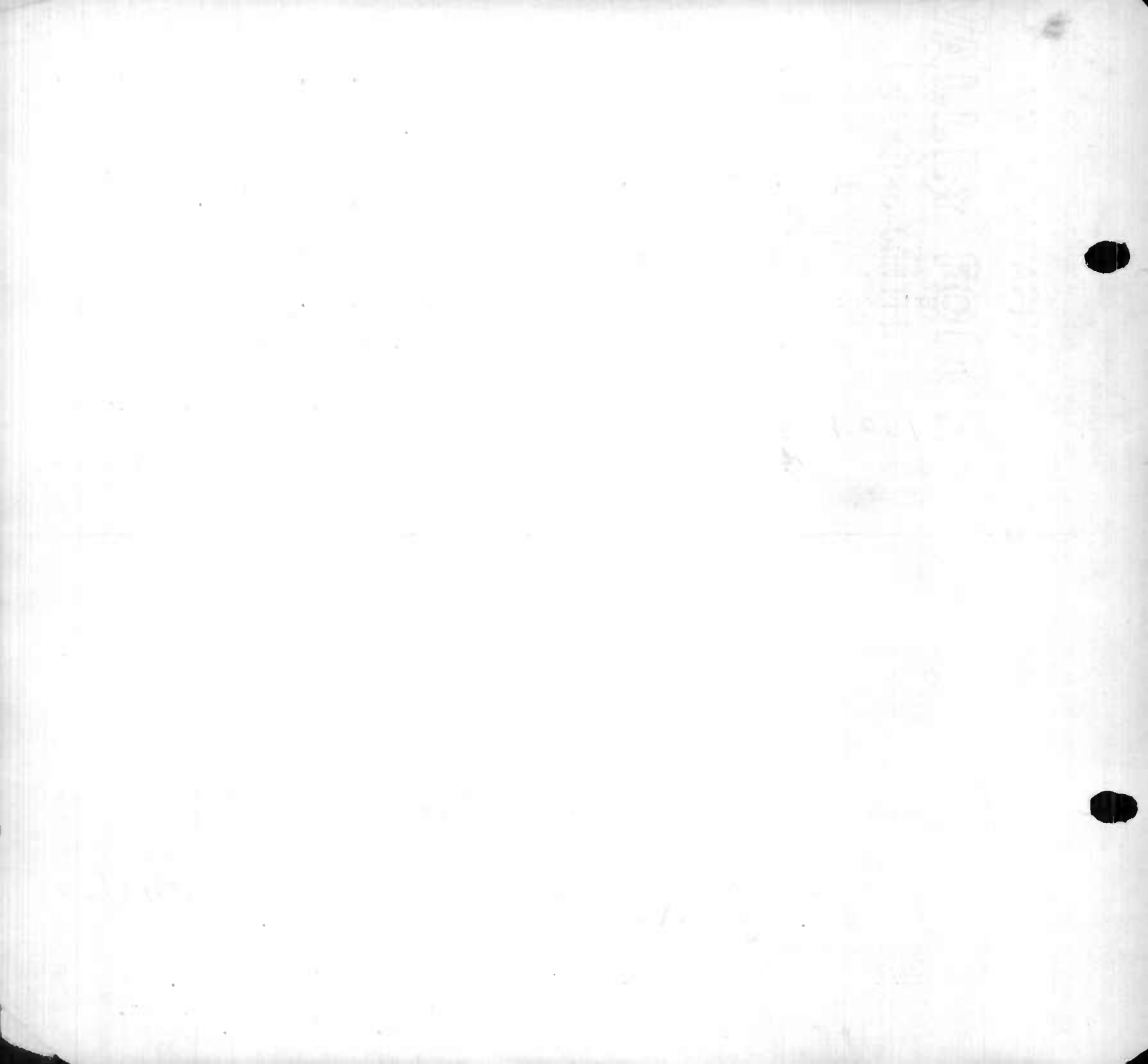
10/10/17

James L. Kennedy

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 10002				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10002	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				GEORGE FRANK DiMATTEI		Oct. 18, 1967 12:05 a. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
00 2912 E. Madison St.				Md. 21205			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				2912 E. Madison St.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
male		white		married		9/7/1889	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Bartender		Madden Cafe		Baltimore, Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Octavio DiMattei				Margaret Schmidt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				213-05-2239 A		Agnes Pokorney DiMattei, wife, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO		7 months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Dec 1966 to Oct 17 1967, that (I) (we) last saw the deceased alive on Oct 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dr. Sylvan Goldberg						10/18/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				Medical Arts Bldg.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/21/67		Moreland Memorial Park		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 20 1967		Robert E. Schimunek		Schimunek Funeral Home, Inc.		2601 E. Madison St.	



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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10003	
BIRTH NO. 67 10003		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) STAPLES, ENMA		2. DATE AND HOUR OF DEATH 10/16/67 12:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 20-02			
		D. STREET ADDRESS (If rural, give location) 18 N ASHBURTON ST.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9/1/00	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Clover, Virginia		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Coleman Gundy			14. MOTHER'S MAIDEN NAME Tabby		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr Langston Staples, same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) UREMIA AND ELECTROLYTE DIS-TURBANCE		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH WEEKS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO		CHRONIC RENAL FAILURE YEARS	
		(B) DUE TO		CHRONIC GLOMERULONEPHRITIS YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2/2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased, from 9/1/67 to 10/16/67 , that (I) (we) lost saw the deceased alive on 10/16/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. Queral		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 10/16/67		
23C. PHYSICIAN'S NAME (Type) F. QUERAL		23D. ADDRESS LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/21/67	24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery	24D. LOCATION (City, town, or county) (State) A A County Md		
25A. DATE REC'D BY HEALTH DEPT. OCT 20 1967	25B. NAME OF REGISTRAR Robert E. Farley	25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave			

STAPLES, ENNA

LUTHERAN HOSPITAL

F C

18 N ASHBURTON ST
BALTIMORE
Md *

CHRONIC SPONGEBOUGH
YEARD
CHRONIC RENAL FAILURE
YEARD
URICEMIA AND ELECTROLYTE DIS-
TUBANCES
YEARD

F. DORR
F. DORR

10/10

d/10
10/10

10/10

10/10

X

LUTHERAN HOSPITAL

10/10

1
B-615

67 10004

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10004

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PETER

BREVING

2. DATE AND HOUR PRONOUNCED DEAD

October 16, 1967

1:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

903 Lake Drive, Apt #1E

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

903 Lake Drive Apt. 1 E

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

11/16/1893

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Capt.

10B. KIND OF BUSINESS OR INDUSTRY

Shipping

11. BIRTHPLACE (State or foreign country)

Denmark

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

099-16-9205A

17. INFORMANT

ADDRESS

J.D. AVENT 222 E. Baltimore St. 21202

18.

178X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of Throat
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/17/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

23B. DATE

10/20/67

23C. NAME of CEMETERY or CREMATORY

London Park

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 20 1967

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

Walter H. 4101 Edmonds Ave

ADDRESS

19670010020

10-1-51

11/15/50 272

Black

Black

off to the right. 200 ft. distance

11/15/50

Black

Black

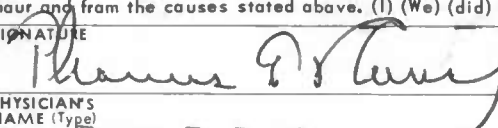
11/15/50

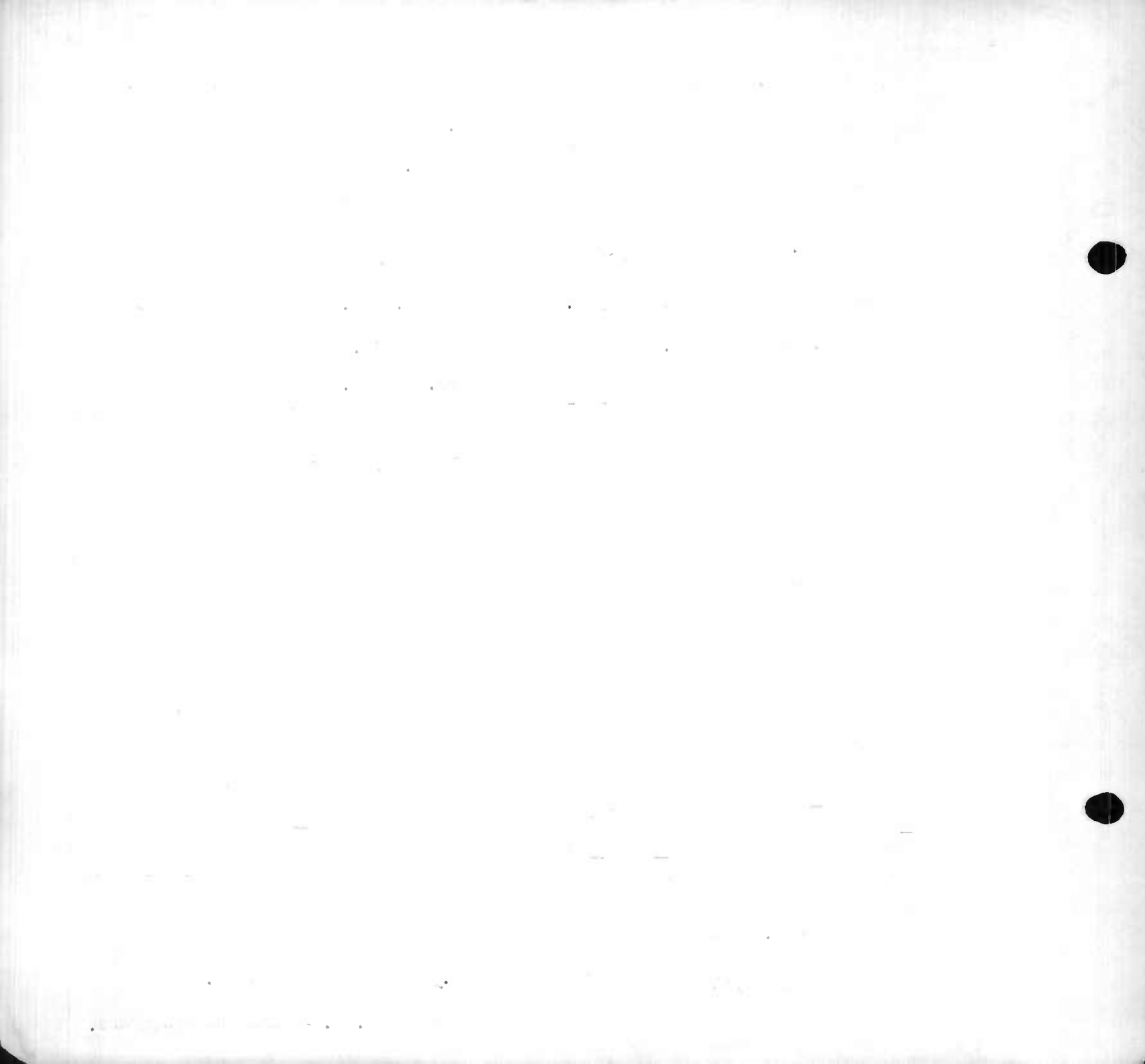
Location of the house

11/15/50

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>67 10005</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 10005</u>	
1. NAME OF DECEASED (Type or Print) Paul Dukehart				2. DATE AND HOUR OF DEATH October 16, 1967 3:25 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 700 Hunting Place				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, give RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 700 Hunting Place			
5. SEX M	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 28/08	9. AGE (In years lost birthday) 59	10. Under 1 Yr. Months Days Hours Min.	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10B. KIND OF BUSINESS OR INDUSTRY Dukehart Co.		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John M. Dukehart, Sr.				14. MOTHER'S MAIDEN NAME Rose E. Huesman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-07-5963		17. INFORMANT Mrs. Mary E. Dukehart 700 Hunting Place		ADDRESS	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) Cerebral thrombosis DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7 weeks	
				(B) Arteriosclerotic CV disease DUE TO		5 yrs+	
				(C)			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 48 to 10/16/67 19 that (I) (we) last saw the deceased alive on 10/16/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  M.D.						23B. DATE SIGNED 10/18/67	
23C. PHYSICIAN'S NAME (Type) Thomas E. Roach				23D. ADDRESS M.D. 5550 Baltimore National Pike			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/19/67		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		ADDRESS	



BALTIMORE CITY HEALTH DEPARTMENT

67-10006 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67-10006

A. 450

BIRTH NO. 67-10006

M.E. CASE NO.

1. NAME OF DECEASED (Herman)
LLOYD ~~AL~~ ALLYN

2. DATE AND HOUR PRONOUNCED DEAD
October 10, 1967 3:55 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Colorado
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
St. Pueblo
D. STREET ADDRESS (If rural, give location)
1117 Blake St.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
00 21 S. Broadway

5. SEX Male

6. RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married

8. DATE OF BIRTH Jan. 30, 1927

9. AGE (In years last birthday) 40

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Career Soldier

11. BIRTHPLACE (State or foreign country) Presho, S.D.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Elbert G. Allyn

14. MOTHER'S MAIDEN NAME Dorothy Herman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1946 to present

16. SOCIAL SECURITY NO.

17. INFORMANT Breece F. H. Fayetteville, N. C.

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Acute purulent meningitis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Skull Fracture

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown

21C. WHERE DID INJURY OCCUR? Unknown

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 10 7 67 ?

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Unknown

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION, REMOVAL (Specify) Removal

23B. DATE 10/18/67

23C. NAME OF CEMETERY or CREMATORY Cross Creek Cemetery

23D. LOCATION (City, town, or county) (State) Cumberland Co., M. N.C.

24A. DATE REC'D BY HEALTH DEPT. OCT 20 1967

24B. NAME OF REGISTRAR Robert E. Fisher

24C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St.

RECEIVED
JAN 10 1964

00

1-10-64

This case was released by Dr. J. in Zh. cum at 9.30 AM 10/16/67
Funeral Director: IMPORTANT
6201
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10007		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10007	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Nellie FROCK		2. DATE AND HOUR OF DEATH 10/16/67 1:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL Hosp 38th & N. Calvert		A. STATE Md. B. COUNTY BALT. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1662 E Cold Spring Lane			
5. SEX F	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1/12/87	9. AGE (In years last birthday) 80	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME DENNIS		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 364-09-3969		17. INFORMANT ADDRESS MRS. Lillian Taylor SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.		(A) Arteriosclerotic heart disease DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.		(B) DUE TO			
19A. DATE OF OPERATION 10/3/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of Femur		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) YES		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NURSING HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Should Nursing Home (no address)	
21D. TIME OF INJURY (APPROX.) 10/3/67		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pt. Slipped & Fell	
22. I certify that (I) (this hospital) attended the deceased from 10/3 1967 to 10/16 1967, that (I) (we) last saw the deceased alive on 10/16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert P. Doyle		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/16/67	
23C. PHYSICIAN'S NAME (Type) ROBERT P DOYLE M.D.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/19/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. OCT 20 1967		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. 1217 St. Paul St.		24H. ADDRESS			

NOTICE TO THE PUBLIC

THE BOARD OF DIRECTORS OF THE

non-med. Released by Med. Examiner's Office. Dr. Palomino
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10008	
BIRTH NO. 67 10008		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 10-18-67 1:25 P.M.	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Coe, Russell					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		A. STATE 2233 E. Fayette St. B. COUNTY C. CITY OR TOWN Baltimore D. STREET ADDRESS Maryland			
5. SEX m	6. RACE w	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) m	8. DATE OF BIRTH 7-9-08	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME NICHOLAS COE		14. MOTHER'S MAIDEN NAME KATY MOORE		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Hospital records	
18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) myocardial infarction (B) ARTERIOSCLEROSIS and (C) coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. chronic bronchitis and emphysema					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Oct 17 19 67 to Oct 18 19 67, that (1) (we) lost saw the deceased alive on Oct 18 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles D. Stewart M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 18 Oct 67	
23C. PHYSICIAN'S NAME (Type) CHARLES D. STEWART M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/21/67		24C. NAME of CEMETERY or CREMATORY Knoll Creg Memorial	
24D. LOCATION Abingdon, Virginia		24E. DATE REC'D BY HEALTH DEPT. OCT 20 1967			
24F. NAME OF REGISTRAR Robert E. Taylor		24G. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. Balto. Md. 21202			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10009

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT STAUFFER

2. DATE AND HOUR PRONOUNCED DEAD

October 18, 1967 4:09 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4108 Newton Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Nov. 8, 1959

9. AGE (In years
last birthday)

7

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Donald E. Stauffer

14. MOTHER'S MAIDEN NAME

Norma E. Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.
none

17. INFORMANT

ADDRESS

Donald E. Stauffer 4108 Newton Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Cerebrocranial injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

10-18-67

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Head Injury

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Narcissus Avenue 168 ft.

south of Rogers Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
10-18-67 12:30 P.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian pushed
in front of moving car

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 19, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10-21-1967

23C. NAME of CEMETERY or CREMATORY

Good Shepherd

23D. LOCATION

(City, town, or county)

Howard Co.

Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 20 1967

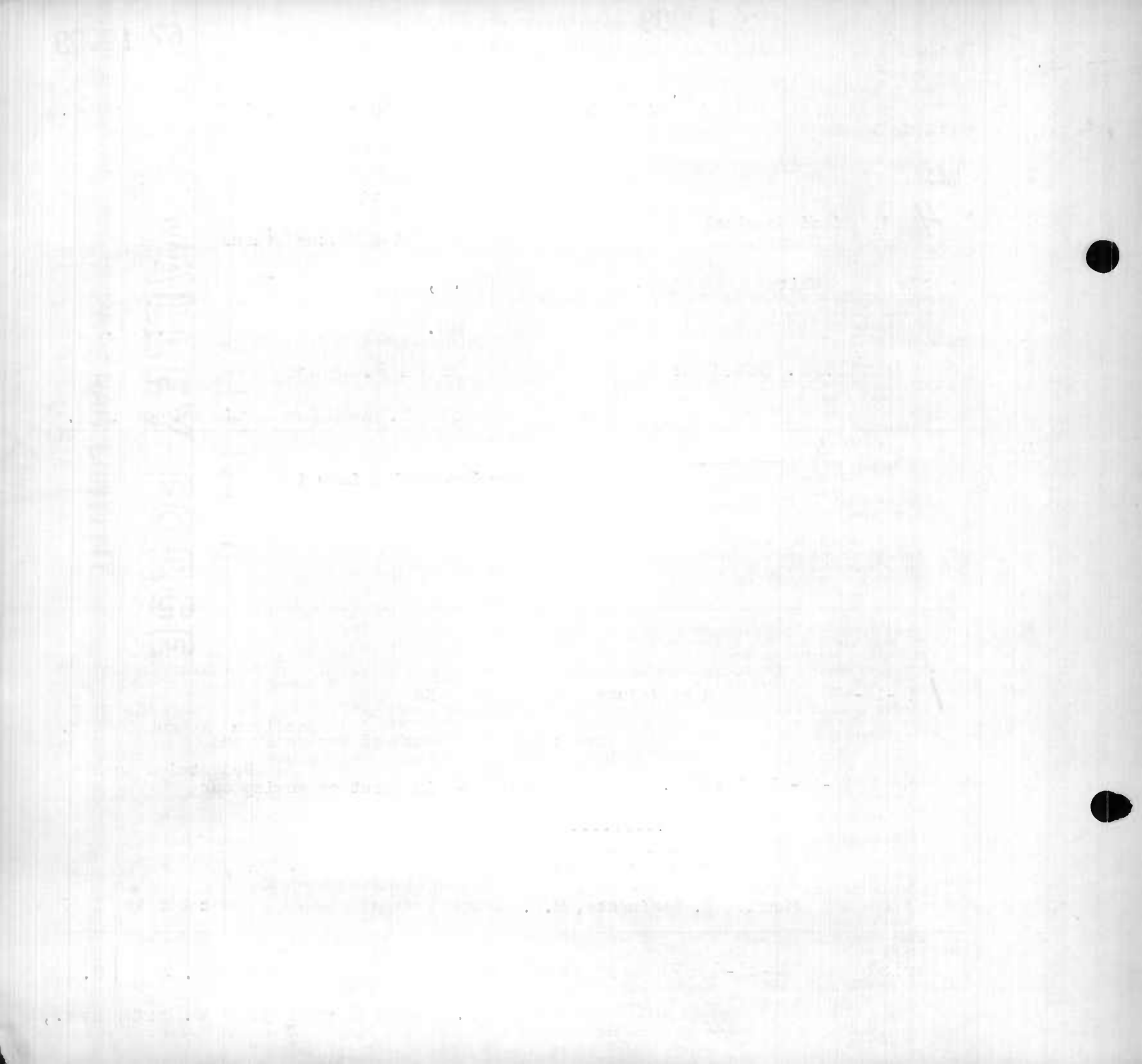
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

G. Howard Strong 3207 W. North Ave.,



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10010

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HERBERT HARDEN

2. DATE AND HOUR PRONOUNCED DEAD

October 18, 1967 11:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

11 North Amity Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

1904

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James

Harden

14. MOTHER'S MAIDEN NAME

Marry Bennett

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-05-6912

17. INFORMANT

Annie Graham 11 N. Amity St.

ADDRESS

18. 163X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma of lung

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 19, 1967

23A. BURIAL CREMATION,
REINTERMENT (Specify)

Burial

23B. DATE

10/23/1967

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

Cedar Hill Md.

(City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 20 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Williams Funeral Home

ADDRESS

3147 N. Schroeder St.

67 10011

BALTIMORE CITY HEALTH DEPARTMENT

67 10011

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN TROTTER

2. DATE AND HOUR PRONOUNCED DEAD

October 15, 1967 9:05 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

W. Lexington & Franklinton Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

218 Carlton Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED (Sep.)

8. DATE OF BIRTH

March 6, 1887

9. AGE (In years
last birthday)

80

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Logan

10B. KIND OF BUSINESS OR INDUSTRY

Brunner's Co. Voz.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-10-7080

17. INFORMANT

John W. Trotter 905 Montford St

ADDRESS

18. E802 X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

railroad tracks

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Pennsylvania Railroad Track #4

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
10-15-67 8:55 A.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Run over by train

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate

M.D.

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 16, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/16/1967

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

Cedar Hill Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 20 1967

24B. NAME OF REGISTRAR

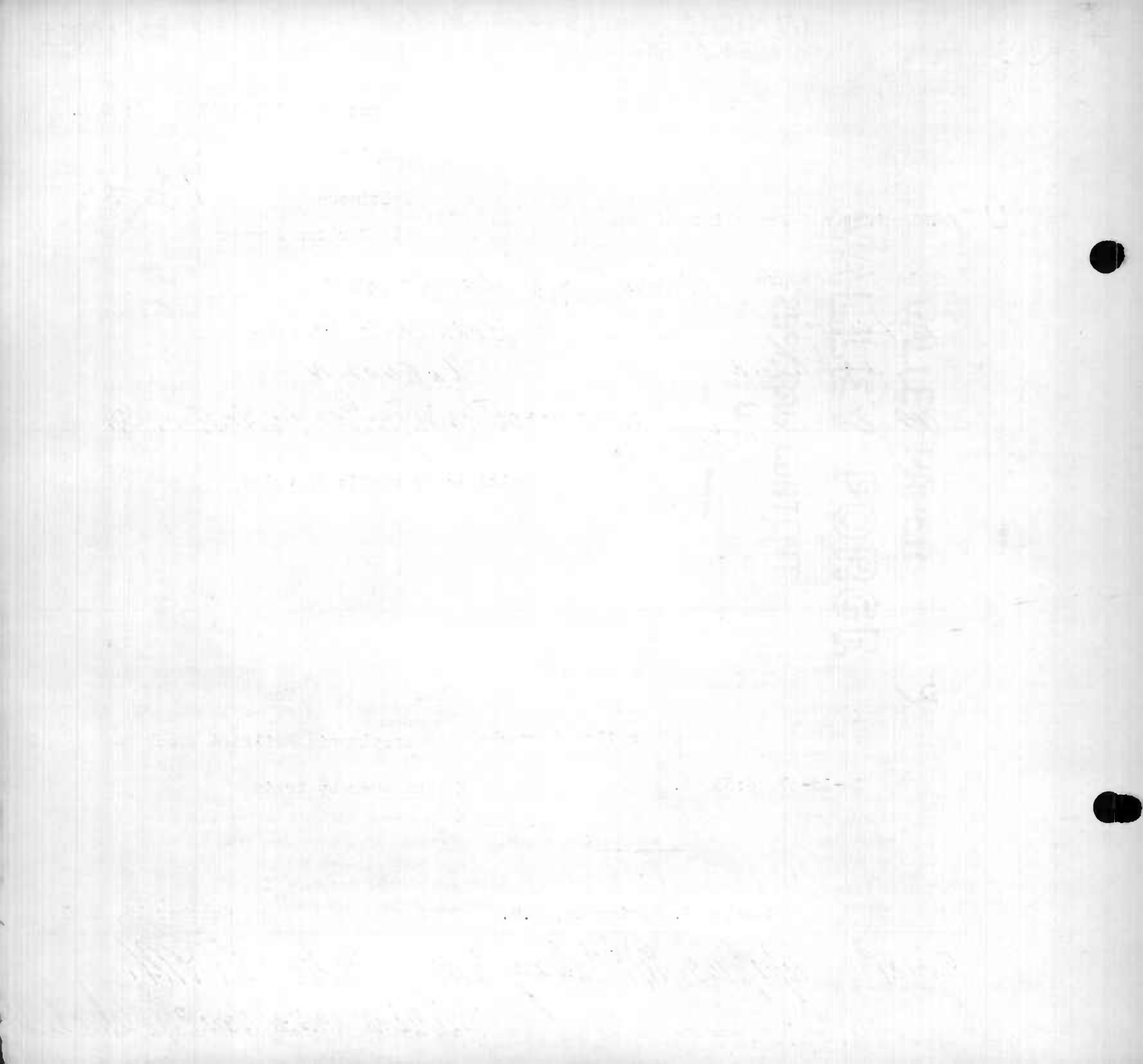
G. B. E. Fisher

24C. FUNERAL DIRECTOR

Williams Funeral Home

ADDRESS

3197 Broadway



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10012				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED No. 67 10012	
1. NAME OF DECEASED (Type or Print) Lillie Byrd				2. DATE AND HOUR OF DEATH Oct. 17, 1967 5:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University of Maryland Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 1636 Moreland Ave.			
5. SEX Female	6. RACE Col.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Feb. 22, 1909	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Halifax Co. Va.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Henry Simmons			14. MOTHER'S MAIDEN NAME Dora ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Lodges Penick 1636 Moreland Ave.		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Acute Myocardial Infarction DUE TO (B) Arteriosclerotic Heart Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 hour Years ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct. 6 19 67 to Oct 17 19 67 , that (I) (we) last saw the deceased alive on Oct 17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R.H. Anderson M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) R.H. ANDERSON				23D. ADDRESS M.D. Univ. of Maryland Hospital Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct 20, 1967		24C. NAME OF CEMETERY or CREMATORY Wm. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Cedar Hill Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 20 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Williams Funeral Home 3197 N. Schroeder St.		ADDRESS	

Female Col.
Housewife

Done ?
Hollister Co. Va.
February 28

1030 Maryland Ave.
Baltimore
Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10013	
BIRTH NO. 67 10013		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WALL, AL BAN		2. DATE AND HOUR OF DEATH October 19, 1967 11:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 9-01	
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 3706 OLD YORK ROAD	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 06-22-86	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mutual man retired		10B. KIND OF BUSINESS OR INDUSTRY Race Tracks		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 218-03-7329A		17. INFORMANT ADDRESS MRS BETTY LEE RULAND 3706 OLD YORK RD, BALTO	
18. 331X I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		(A) Cerebro Vascular Accident DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerosis DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 16, 1967 to October 19, 1967 , that (I) (we) last saw the deceased alive on October 19, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED October 19, 1967	
23C. PHYSICIAN'S NAME (Type) MIGUEL SANCHEZ PALACIOS		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/23/67		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		24E. ADDRESS 21229			
25A. DATE REC'D BY HEALTH DEPT. OCT 20 1967		25B. NAME OF REGISTRAR Robert E. Sankey, M.D.		25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St	

11-30-4

11-30-4

11-30-4

MARYLAND

BALTIMORE

3106 Old York Road

0-25-86 24

MARYLAND

AMERICAN

UNION MEMORIAL HOSPITAL

M W 20000

UNKNOWN

MRS BETTY LEE RYAN

Cerebral Vascular Accident

Acute onset

po

October 14, 63
October 14, 63
October 14, 63

October 14, 63

X

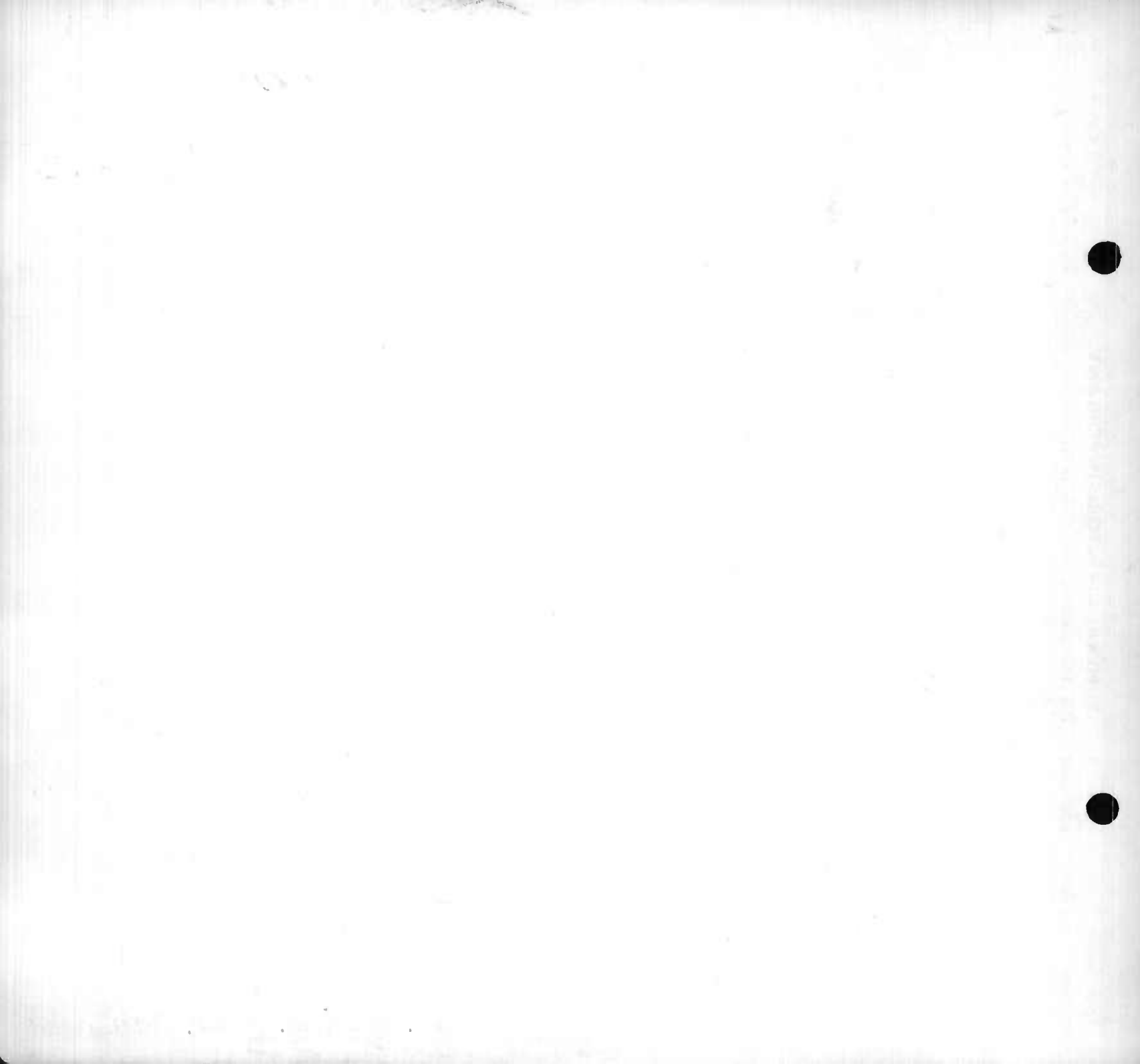
MICHAEL STANLEY PATRICK UNION MEMORIAL HOSPITAL

(Signature)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

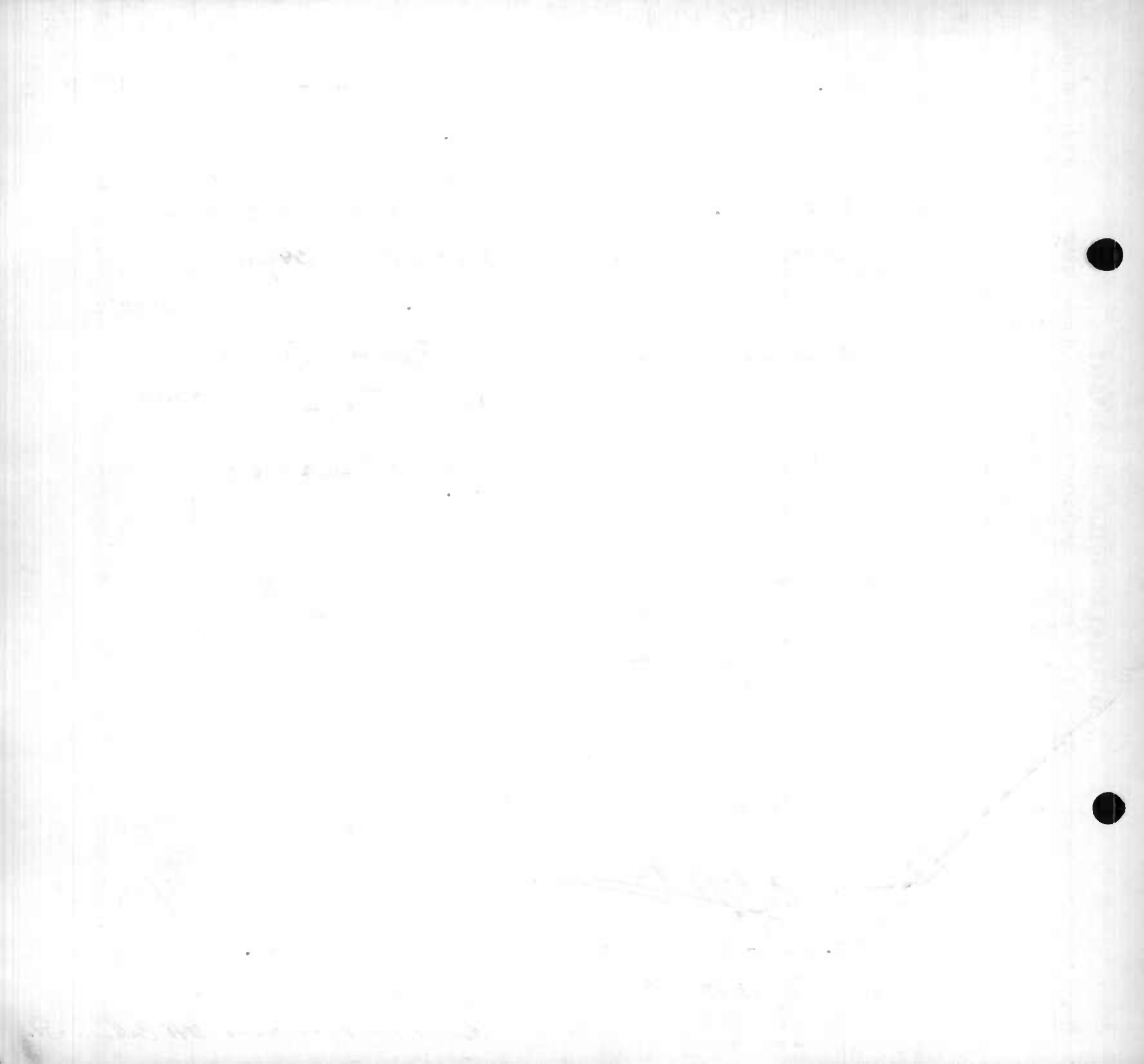
BALTIMORE CITY HEALTH DEPARTMENT									
67 10014 CERTIFICATE OF DEATH					Registered No. 67 10014				
BIRTH NO. 67 10014					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <i>Margaret R. Curry</i>					2. DATE AND HOUR OF DEATH <i>10-19-67</i> <i>2 A</i> M.				
3. PLACE OF DEATH <i>Union Memorial Hospital Baltimore-18 Md.</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 18</i> <i>12-02</i>				
D. STREET ADDRESS (If rural, give location) <i>Homewood Apts-31st + Charles St</i>					5. SEX <i>F</i>				
6. RACE <i>W</i>					7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never Married</i>				
8. DATE OF BIRTH <i>9-7-83</i>					9. AGE (In years last birthday) <i>84</i>				
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>					11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					13. FATHER'S NAME <i>Benjamin Franklin Curry</i>				
14. MOTHER'S MAIDEN NAME <i>Sarah Elizabeth Mooney</i>					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				
16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Ruptured aortic aneurysm</i>					INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerotic cardiovascular disease</i>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>July 19 58</i> to <i>Oct 19 19 67</i> , that (I) (was) last saw the deceased alive on <i>October 17 19 67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death.									
23A. SIGNATURE <i>Alfred H. Ossman Jr.</i> M.D.					23B. DATE SIGNED <i>10-19-67</i>				
23C. PHYSICIAN'S NAME (Type) <i>Alfred G. Ossman Jr.</i> M.D.					23D. ADDRESS <i>1101 St Paul St Baltimore 2 Md.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>10/21/67</i>				
24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>					24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 20 1967</i>					25B. NAME OF REGISTRAR <i>Robert E. Jarboe</i>				
25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran, Inc. 3000 E. Baltimore St</i>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 10015		CERTIFICATE OF DEATH		Registered No. 67 10015	
1. NAME OF DECEASED (Type or Print) Mrs. Maude Tucker				2. DATE AND HOUR OF DEATH 10-19-67 6:35 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3414 Auchentoroly Terrence					
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-25-07	9. AGE (In years lost birthday) 39 yr.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME Richard Williams			14. MOTHER'S MAIDEN NAME Sophia Taylor			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.			17. INFORMANT RUFUS TUCKER			ADDRESS SAME			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) Probable Acute Pulmonary edema.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 hours			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
21A. DATE OF OPERATION 10-23-67		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21D. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21E. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21C. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21D. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from on 10/19 19 67 to 19 that (I) (we) lost saw the deceased alive on 10/19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Dr. Jean-Claude Victor				23B. DATE SIGNED 10/19/67					
23C. PHYSICIAN'S NAME (Type) Dr. Jean-Claude Victor				23D. ADDRESS 1514 Division St.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-23-67		24C. NAME OF CEMETERY or CREMATORY NEW CATHARAL Cem.		24D. LOCATION (City, town, or county) (State) BALTO., Md.			
25A. DATE REC'D BY HEALTH DEPT. OCT 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Nelson Funeral Home		ADDRESS 1548 Calhoun St.			



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67 10016 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10016

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		GUS PEPPER		2. DATE AND HOUR PRONOUNCED DEAD October 13, 1967 8:19 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION St Agnes Hospital (DOA)				A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 308 S. Collins Ave.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-15-99	9. AGE (In years last birthday) 68	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Greece	
13. FATHER'S NAME Unknown			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No			14. MOTHER'S MAIDEN NAME Unknown		
16. SOCIAL SECURITY NO. 174-01-2412			17. INFORMANT ADDRESS Mrs. Mary Pepper, 129 Millcheek Ave. P. O. Box 484, Pottsville, Pa. 17901		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23A. BURIAL CREMATION, REMOVAL (Specify) Burial			
23B. DATE 10/19/67		23C. NAME of CEMETERY or CREMATORY Greek Orthodox Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT. OCT 20 1967		24B. NAME OF REGISTRAR Robert E. Farley		24C. FUNERAL DIRECTOR ADDRESS Nicholas T. Matthews 3021 Eastern Ave., Baltimore, Md.	

ACTUAL SIGNATURE *Charles S. Springate*
EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
10-14-67

FUNERAL DIRECTOR: IMPORTANT

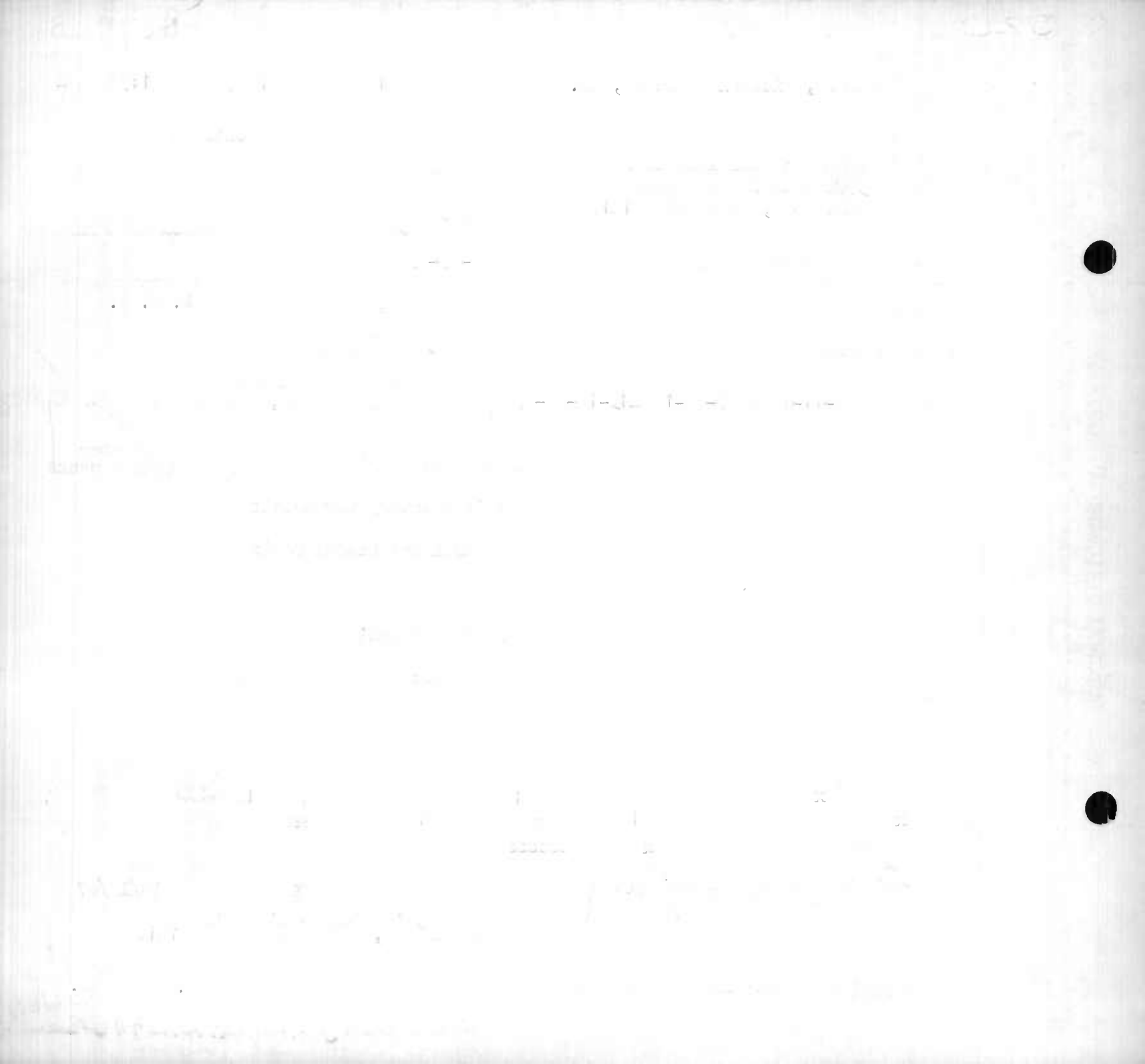
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 10017		CERTIFICATE OF DEATH		67 10017	
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) George P Angelos			Oct. 15, 1967 6:30P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 1105 E. Fayette Street			A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 828 South Ponca Street		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-15-1889	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker		10B. KIND OF BUSINESS OR INDUSTRY Steel	11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Peter Angelos			14. MOTHER'S MAIDEN NAME Mary		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO. 193-10-5032	17. INFORMANT Dr. Peter Angelos 1505 26th St. Wash. DC		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 331X I			CAUSE OF DEATH (A) CVA DUE TO (B) Arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 day Sev. Yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Left Hemiparesis			7 yrs.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) XXXXXX attended the deceased from Jan 23, 1962 to Oct. 15, 1967 , that (I) (X) last saw the deceased alive on Oct. 14, 1967 and that in (my) XX opinion death occurred on the date and hour and from the causes stated above. (I) XX (did) XXXX view the body after death.					
23A. SIGNATURE E. Ellsworth Cook				23B. DATE SIGNED Oct. 15, 1967	
23C. PHYSICIAN'S NAME (Type) E. Ellsworth Cook				23D. ADDRESS 2431 Maryland Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/18/67	24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR NICHOLAS T. MATTHEWS 3021 EASTERN AVENUE, BALTIMORE	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.
67 10018		67 10018		67 10018
BIRTH NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH
M.E. CASE NO.		Koenig, Michael Marcus, Sr.		16 OCTOBER 1967 1:50 A.M.
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		27 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		A. STATE B. COUNTY MARYLAND BALTIMORE CITY
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MALE		CAUCASION		MARRIED
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
ENGINEER				4-25-85
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)
JOHN KOENIG		FRANCES FISHER		82
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)
YES 7-11-17 TO 7-22-18		213-14-99-83		RASPEBURG, MARYLAND
17. INFORMANT		12. CITIZEN OF WHAT COUNTRY?		17. ADDRESS
HOSPITAL RECORDS		U. S. A.		3900 LOCH RAVEN BLVD, BALTIMORE, MARYLAND 21218
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		greater than 6 weeks
ANTECEDENT CAUSES		(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
		Bronchopneumonia		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
2				Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (X) (this hospital) attended the deceased from 12 SEPTEMBER 19 67 to 16 OCTOBER 19 67, that (X) (we) last saw the deceased alive on 16 OCTOBER 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
George W Gaffney M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				10/17/67
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
		3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial		10-19-1967		Parkwood Cemetery
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
OCT 20 1967		Robert E. Farber		Lorraine Funeral Home 2461 Belton



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 10019</u>	
BIRTH NO. <u>67-19999 67 10019</u> CERTIFICATE OF DEATH					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>TORBIT, YOLANDA SHAWENTAE</u>			2. DATE AND HOUR OF DEATH <u>10-19-67 12:05 A.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UN. OF MD. HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>20-07</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE CITY 21229</u>		
			D. STREET ADDRESS (If rural, give location) <u>408 N. EDGEWOOD ST.</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>10-4-67</u>	9. AGE (In years last birthday) <u>15</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JOHN D. TORBIT</u>			14. MOTHER'S MAIDEN NAME <u>WILLIE BELLE THOMPSON</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT ADDRESS <u>HOSPITAL CHART</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>759.31</u> <u>TRISOMY 18</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 DAYS</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>IMMATURITY</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>10-10-1967</u> to <u>10-19-1967</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>10-19-1967</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Theodore Wolff</u>			M.D.	Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <u>10-19-67</u>
23C. PHYSICIAN'S NAME (Type) <u>THEODORE WOLFF M.D.</u>			23D. ADDRESS <u>UN. OF MD. HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10-20-67</u>	24C. NAME OF CEMETERY or CREMATORY <u>Western Star Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 20 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Morton E. Dyett F.H. 1701 Laurens St.</u>	

General 10-22-23 Martin's Case, the
Lester's Day 7-11-23

47-88-89 LB 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10020	
J-525		67 10020	
BIRTH NO.		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Johnson, Anna</i> JOHNSON, ANNA Rev.	
2. DATE AND HOUR OF DEATH <i>10/18/67</i> 8:00 PM		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STREET ADDRESS (If rural, give location)	
A. STATE <i>MD</i> MARYLAND		B. COUNTY <i>Baltimore</i> BALTIMORE	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
E. CITY OR TOWN <i>Baltimore</i> BALTIMORE		F. STREET ADDRESS <i>622 W. Lafayette Ave.</i> 12127	
6. SEX <i>F</i> FEMALE	7. RACE <i>N</i> NEGRO	8. MARIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED	9. DATE OF BIRTH <i>8/22/14</i> 8/22/14
10. AGE (In years last birthday) <i>53</i> 53	11. If Under 1 Yr. Months Days	12. If Under 24 Hrs. Hours Min.	13. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Church</i>	
11. BIRTHPLACE (State or foreign country) <i>New York City, N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME <i>JAMES</i>		14. MOTHER'S MAIDEN NAME <i>JOHNSON, MATTIE GoldMAN</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>RECORDS: BCH 4940 EASTERN AVE., BALTO., MD.</i>		ADDRESS <i>21224</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Carcinoma Breast</i>	
ANTECEDENT CAUSES		(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <i>10/12/66</i> 19 to <i>10/18/67</i> 19		tho (I) (we) lost saw the deceased alive on <i>10/12/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <i>Robert N. Hill</i> M.D.		23B. DATE SIGNED <i>10/18/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert N. Hill</i> M.D.		23D. ADDRESS <i>BCH 4940 EASTERN AVE. BALTO., MD. 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-23-67</i>	
24C. NAME OF CEMETERY or CREMATORY <i>McKenney Cemetery</i>		24D. LOCATION <i>McKenney, Va.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>Oct 20 1967</i>		25B. NAME OF REGISTRAR <i>John E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Morton E. Dyett F.H.</i>		ADDRESS <i>1701 Laurens</i>	

Book 11
Chapter 11
Golden

1

Book 11 is 2-3 pages long
written by D.H. 11. 1911

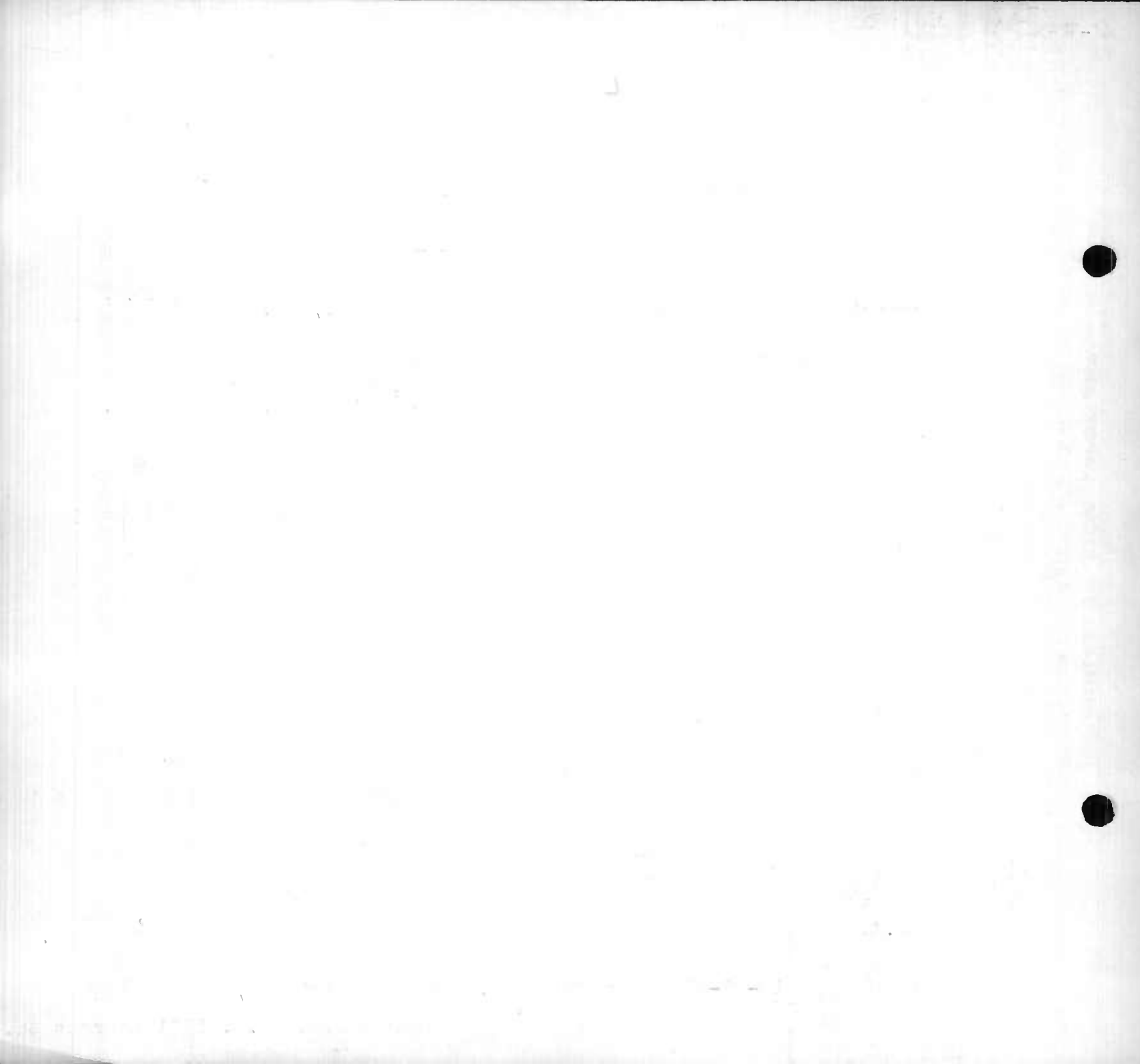
44-58-32

ME

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10021		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10021	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MICKEY, MARY L.		2. DATE AND HOUR OF DEATH 10/19/67 1:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 31 (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITAL 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 103 WALNUT AVENUE			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 4-2-09	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) GOOCHLAND CO., VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WESLEY JONES		14. MOTHER'S MAIDEN NAME MARY JONES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTIMORE, MD. 21224	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) DUE TO ASCVD (B) DUE TO CHRONICALLY INSUFFICIENCY (C) _____		INTERVAL BETWEEN ONSET AND DEATH 5 years.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/19/67 to 10/19/67 , that (I) (we) last saw the deceased alive on 10/19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jack Brandes		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) DR. JACK BRANDES		23D. ADDRESS BALTIMORE 21224, MARYLAND BALTIMORE CITY HOSPITALS 4940 EASTERN AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 10-23-67	24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 10022</u>
BIRTH NO. <u>67 10022</u>		CERTIFICATE OF DEATH		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>WALLACE, LENA E.</u>		2. DATE AND HOUR OF DEATH <u>16th Oct. 1967</u> <u>2-35 A.M.</u>
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL</u> <u>10-23-67</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1120 ABBOTT CT.</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11-7-89</u>	9. AGE (In years lost birthday) <u>78</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Belair, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Ralph Hill</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-3926</u>		17. INFORMANT <u>Harry Wallace 1120 Abbott Ct.</u>
18. <u>600.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) CAUSE OF DEATH <u>Chronic Renal failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 MONTHS.</u>
(B) DUE TO <u>Chronic Pyelonephritis</u>		(C) <u>UNKNOWN.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes) <input checked="" type="checkbox"/> (No) <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>10-3-67</u> 19 <u>67</u> to <u>10-16-</u> 19 <u>67</u> , that (I) <u>we</u> last saw the deceased alive on <u>10-16-</u> 19 <u>67</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We did</u> (did not) view the body after death.				
23A. SIGNATURE <u>E. Vera</u>		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10-16-67.</u>
23C. PHYSICIAN'S NAME (Type) <u>E. VERA</u>		23D. ADDRESS M.D. <u>LUTHERAN HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10-19-67</u>	24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 20 1967</u>	25B. NAME OF REGISTRAR <u>R. J. Collick</u>	25C. FUNERAL DIRECTOR ADDRESS <u>2431 E. Oliver St.</u>		

V.S.153

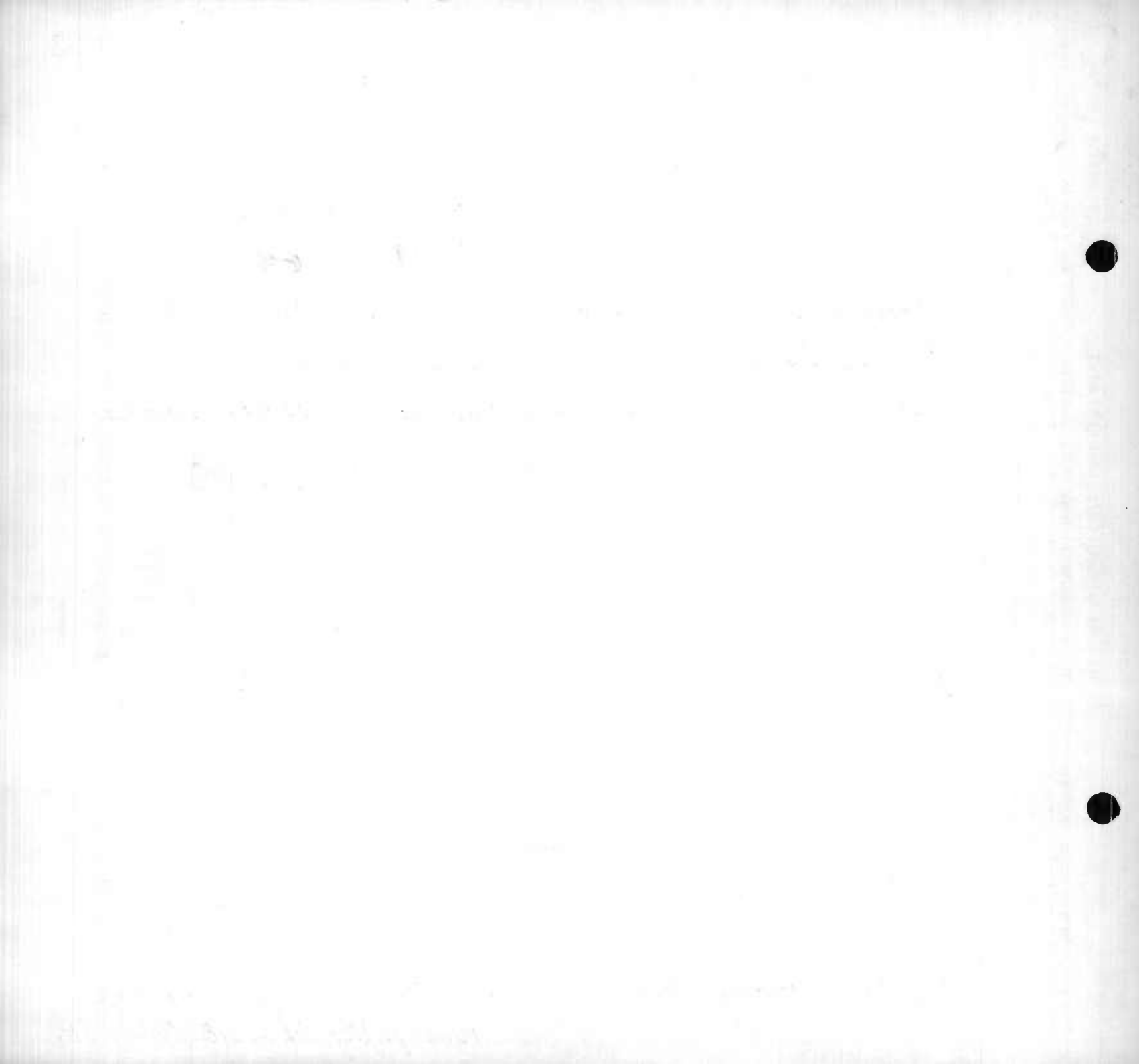
10-23-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 10023 CERTIFICATE OF DEATH					Registered No. 370408 67 10023				
BIRTH NO. 67 10023					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) LOVE ELLEN M.					2. DATE AND HOUR OF DEATH 10/16/67 3:10 PM				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE 42					A. STATE MARYLAND B. COUNTY BALTIMORE				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 1609 BRUCE STREET				
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 2/15/99		9. AGE (In years last birthday) 68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Payne					14. MOTHER'S MAIDEN NAME Bettie Wolfe				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-22-2631		17. INFORMANT Mrs. Ora Jones 1517 Presser Ct.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) G. I. Bleeding & Pancreatic neoplasm (B) Uraemic Coma (C)				
INTERVAL BETWEEN ONSET AND DEATH									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 9/26/67			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED pancreatic neoplasm			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 8/20 1967 to 10/16 1967, that (we) last saw the deceased alive on 10/16 1967, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE D. J. Pradhan					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 10/16/67	
23C. PHYSICIAN'S NAME (Type) D. J. PRADHAN					23D. ADDRESS SINAI HOSPITAL BALTIMORE				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-21-67		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial PK.			24D. LOCATION (City, town, or county) (State) Arbutus, Maryland		
25A. DATE REC'D BY HEALTH DEPT. OCT 20 1967			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR ADDRESS Randolph J. Collick 2431 E. Oliver St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10024				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10024	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Anna M. Behr</i>			
2. DATE AND HOUR OF DEATH <i>Oct. 19, 1967</i>				1 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>35 Church Home and Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>2706</i> D. STREET ADDRESS (If rural, give location) <i>5603 Birchwood Ave.</i>			
5. SEX <i>female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>2/26/89</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>John J. Ostermann</i>				
14. MOTHER'S MAIDEN NAME <i>Catherine Bauernfeind</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				
16. SOCIAL SECURITY NO. <i>none</i>			17. INFORMANT ADDRESS <i>George J. Behr 114 N. Streeper St.</i>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>420.11</i> <i>acute myocardial infarction 20 min</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>ant arcl cvdman 5 yr</i>				INTERVAL BETWEEN ONSET AND DEATH <i>20 min</i> <i>5 yr</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>none</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>none</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1966</i> to <i>10/19</i> 19 <i>67</i> . that (I) (we) last saw the deceased alive on <i>10/18</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Maurice Feldman</i> M.D.				23B. DATE SIGNED <i>10/19/67</i>			
23C. PHYSICIAN'S NAME (Type) <i>Maurice Feldman</i>				23D. ADDRESS M.D. <i>2 E. READ ST. BALTO MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>10/23/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>Oct 20 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbairn</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc Baltimore, Md.</i>		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

20 BIRTH NO. 64-21397		67 10025		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10025	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MAUREEN MINNICK				2. DATE AND HOUR OF DEATH 10/19/67 12:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSP GREENE & LOMBARD STS.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write "URA" and give township) BALTIMORE 27-07 D. STREET ADDRESS (If rural, give location) 6867 MC CLEAN BLVD			
5. SEX FEMALE	6. RACE CAU	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH 8/6/64	9. AGE (In years last birthday) 3	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland?		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLIFFORD J MINNICK				14. MOTHER'S MAIDEN NAME JOYCE LUCAS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT SHAR Mrs. Joyce Kinniard ADDRESS same			
18. 75-2 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) PNEUMONIA- DUE TO (B) HYDROCEPHALUS DUE TO (C) SEPTICEMIA				INTERVAL BETWEEN ONSET AND DEATH 3 days 3 yrs 2 mos 7 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 10/18/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Suspected PULMONARY emboli		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/18 19 67 to 10/19 19 67 , that (I) (we) last saw the deceased alive on 10/19 12:45 AM 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Andrius S. Stearns M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 10/19/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/23/67		24C. NAME OF CEMETERY or CREMATORY Moreland Pk. Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 20 1967		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md.			

Handwritten notes on the right margin, including "10/15/18" and "10/16/18".

10/15/18

10/15/18

10/15/18

UNIVERSITY OF MICHIGAN
EXECUTIVE & ADMINISTRATIVE

ADMINISTRATIVE
OFFICE OF THE CHANCELLOR

10/15/18

CHANCELLOR

CLIFFORD T. MINICK JR. RUCAS

CHANCELLOR

ADMINISTRATIVE

OFFICE OF THE CHANCELLOR

ADMINISTRATIVE

10/15/18

10/15/18

10/15/18

10/15/18

Handwritten signature

10/15/18

10/15/18

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10026	
BIRTH NO. 67 10026		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Thomas Edward Ashley		2. DATE AND HOUR OF DEATH 10/18/67 7:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp		A. STATE Md. B. COUNTY Balt. City			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
44		D. STREET ADDRESS (If rural, give location) 6108 Birchwood Ave			
5. SEX M	6. RACE W	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 06-01-1908	9. AGE (in years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sandwich worker Balt City		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Thomas S. Ashley		14. MOTHER'S MAIDEN NAME Sparwasser	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 212-10-5787		17. INFORMANT wife Anna M. Ashley	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction		CAUSE OF DEATH (A) DUE TO Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH Same	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO		(C) Chf. Fail.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/18/67 to 10/18/67 , that (I) (we) last saw the deceased alive on 10/18/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry J. Weckesser		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/18/67	
23C. PHYSICIAN'S NAME (Type) BARRY J. WECKESSER M.D.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/23/67		24C. NAME OF CEMETERY or CREMATORY Balto. National Cem.	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 20 1967			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.			

Thomas Memorial Hosp

1000 1st St

6108 Birchwood Ave
06-01-08

W M

Thomas S. Oakley

U.S. Maryland
Class of 1908
Wife

Acute myocardial infarction
Pneumonia

George H. H. H.

4/18

4/18

4/18

4/18

4/18

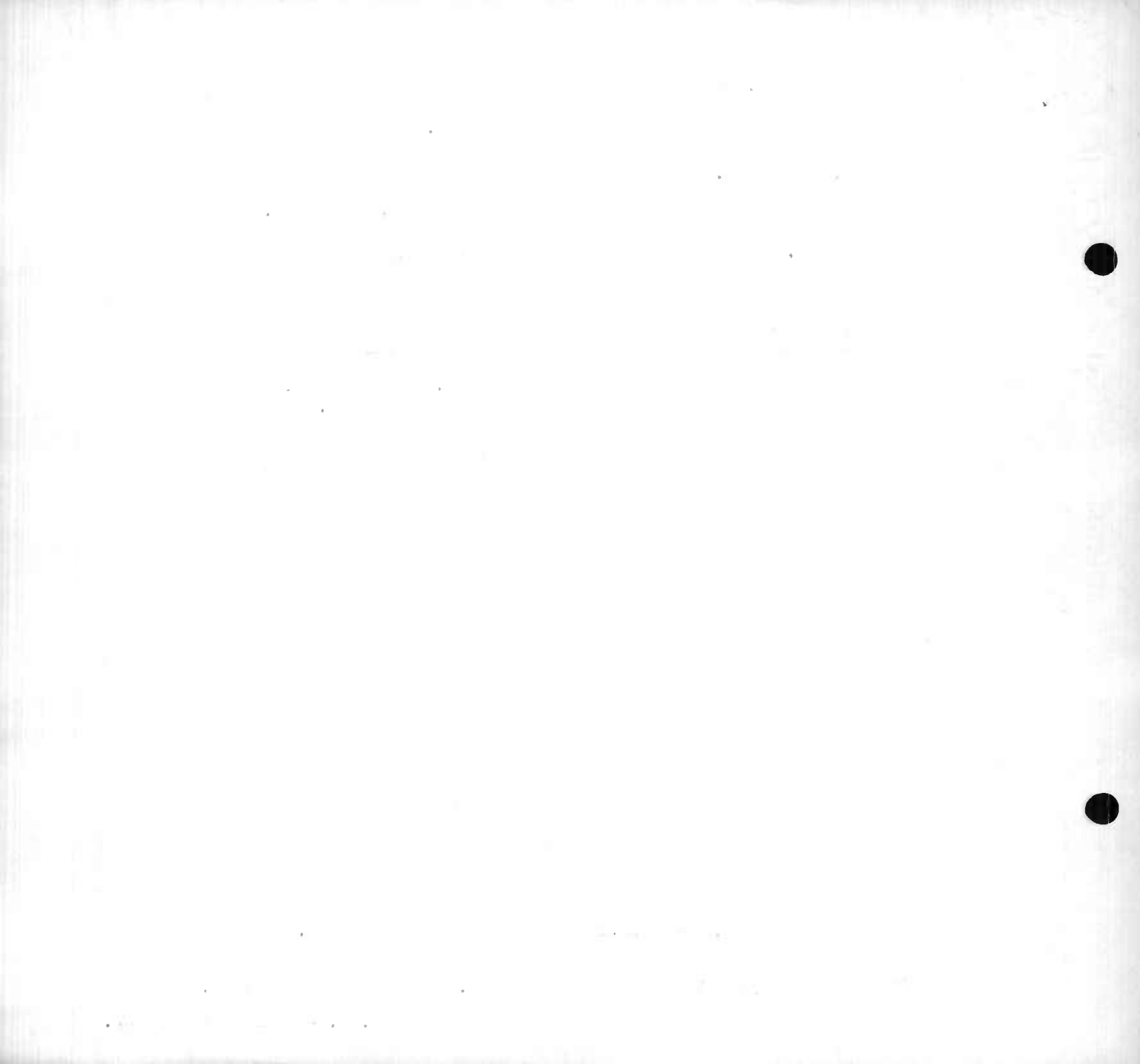
1000 1st St

1000 1st St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

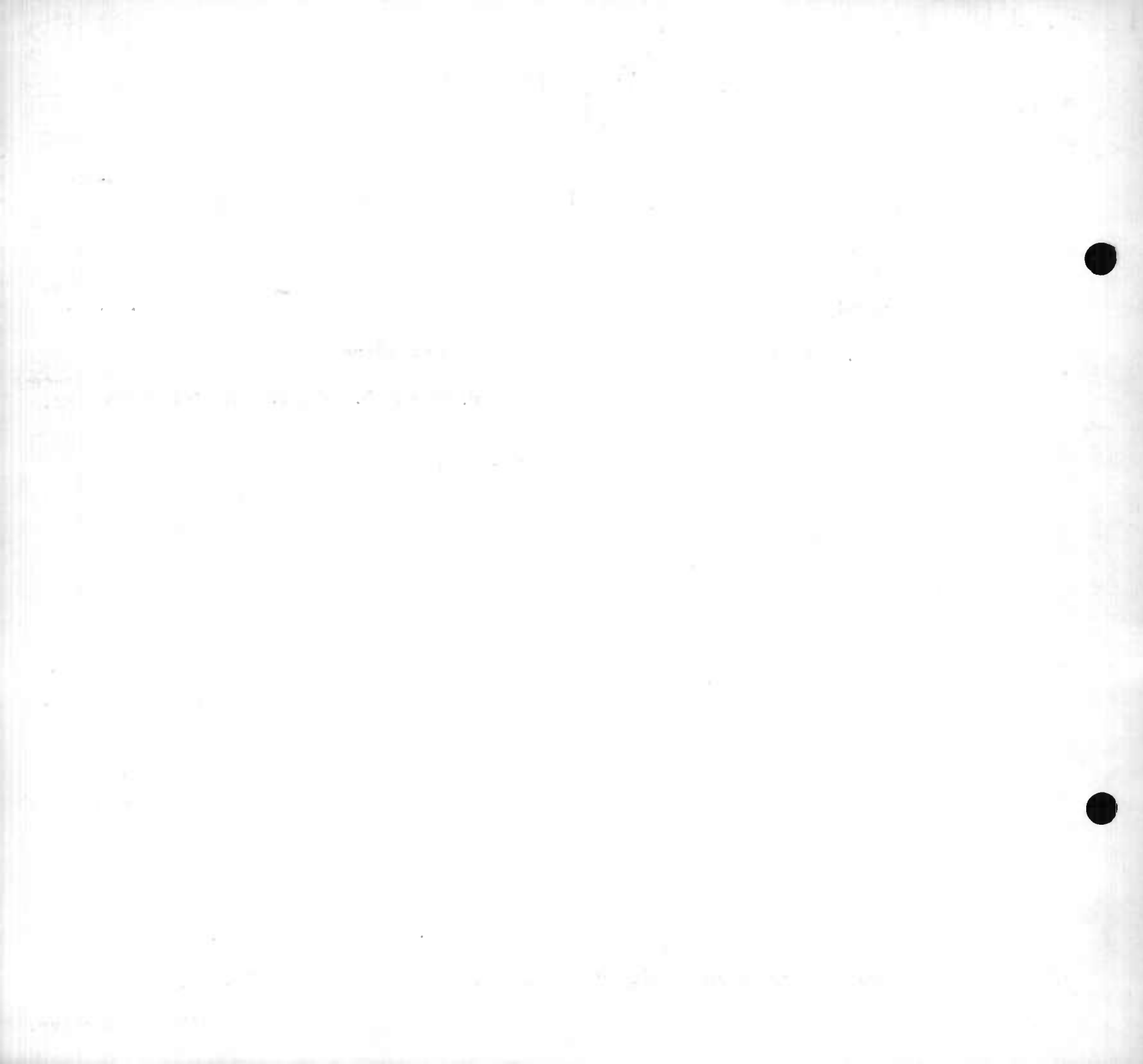
BIRTH NO. 67 10027				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10027	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Louise W. Ellers				2. DATE AND HOUR OF DEATH October 16, 1967 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 100 S. Gilmore St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 100 S. Gilmore St.			
5. SEX F	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH May 24/13		9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Tyler				14. MOTHER'S MAIDEN NAME Nellie Daffin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Dolores Kiszner 707 Academy Rd.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X1 Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 2 yrs.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct. 1964 to Oct 16 1967 , that (I) (we) last saw the deceased alive on Oct. 2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Morris B. Schreiber				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10-17-67	
23C. PHYSICIAN'S NAME (Type) Morris B. Schreiber				23D. ADDRESS M.D. 1519 Lombard St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/19/67		24C. NAME of CEMETERY or CREMATORY Meadowridge Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Oct 20 1967		25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Av.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

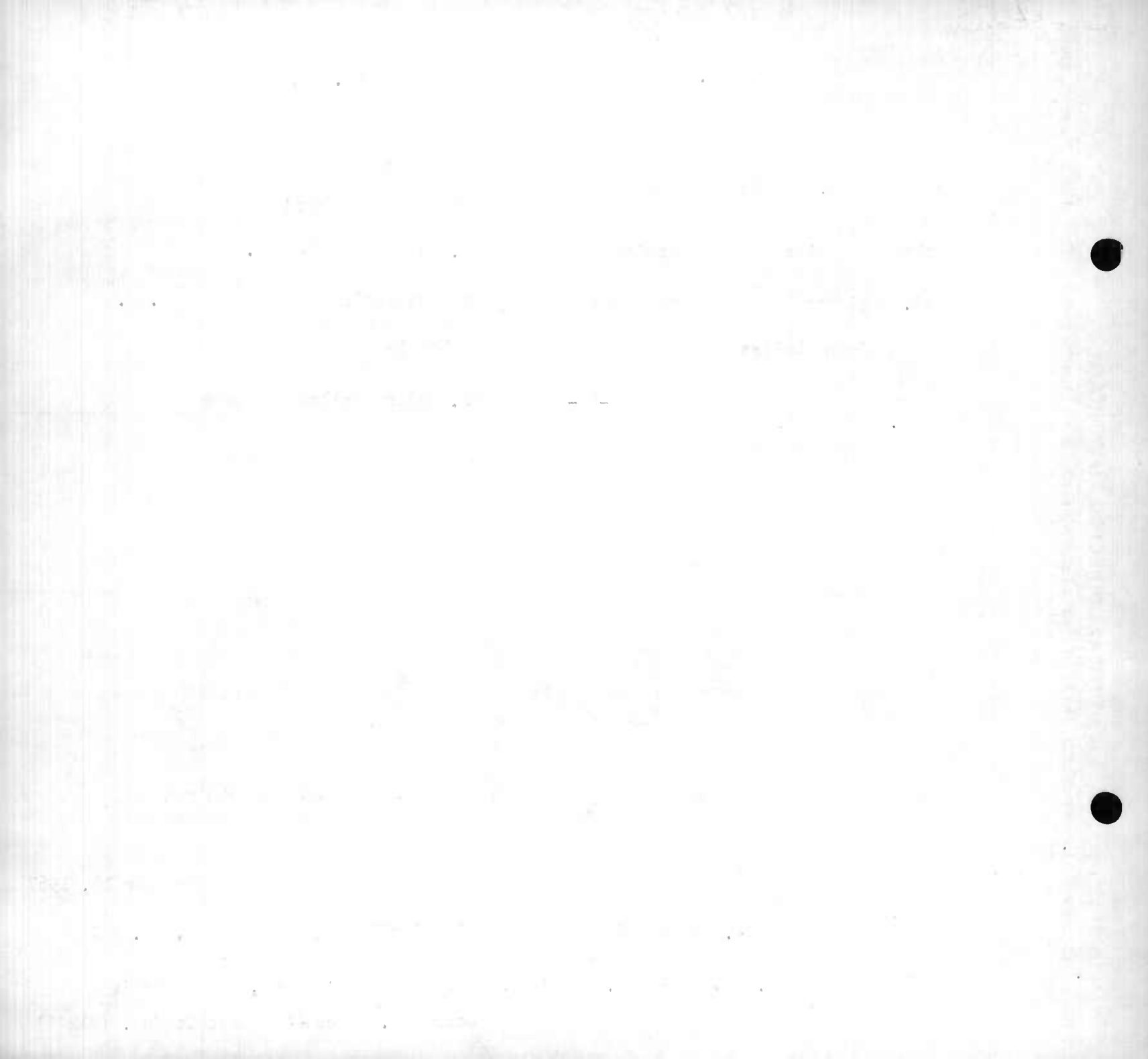
BIRTH NO. 67 10028		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10028	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Ella M. Selters (Ella Mary)</i>		2. DATE AND HOUR OF DEATH <i>10-17-67 3:45 P. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>25-04</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21225</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>421 Annabel Ave.</i>	
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>6-21-1885</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>John T. Hutson</i>		14. MOTHER'S MAIDEN NAME <i>Anna Simon</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Vernon L. Selters Bayside Beach Md.</i>	
18. <i>42011</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Acute Myocardial Infarction</i> DUE TO (B) <i>Generalized Arteriosclerosis</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-17 1967</i> to <i>10-17 1967</i> , that (I) (we) last saw the deceased alive on <i>10-17 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Donald M. Wood</i>				23B. DATE SIGNED <i>10-17-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Donald Wood</i>				23D. ADDRESS <i>1213 Light Street</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/20/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Glen Haven Memorial Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Glen Burnie, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 20 1967</i>			
25B. NAME OF REGISTRAR <i>Paul E. Fulkerson</i>		25C. FUNERAL DIRECTOR <i>M. C. Cully Farnace Home</i>			
25D. ADDRESS <i>237 Patapsco Ave.</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10029	
BIRTH NO. 67 10029		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN D. DALLAS		2. DATE AND HOUR OF DEATH Oct. 16, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 So. Baltimore General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 801 Gretna Court			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 3, 1902	9. AGE (In years last birthday) 65 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stat. Engineer		10B. KIND OF BUSINESS OR INDUSTRY School Board		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME John Dallas		14. MOTHER'S MAIDEN NAME Cassie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-12-6082		17. INFORMANT Mrs. Helen Dallas Same	
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebro-Vascular Accident DUE TO (B) ASCRHD - Severe DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 15, 1966 to 9/19/67 19 that (I) (we) last saw the deceased alive on 9/19/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Andrew R. Sosnowski		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED October 16, 1967	
23C. PHYSICIAN'S NAME (Type) Andrew R. Sosnowski		23D. ADDRESS 4016 Ritchie Highway Balto. Md. 21225			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 21, 1967		24C. NAME OF CEMETERY or CREMATORY St. Mary's Cemetery	
24D. LOCATION (City, town, or county) (State) Shenandoah, Pennsylvania		25A. DATE REC'D BY HEALTH DEPT. OCT 20 1967		25B. NAME OF REGISTRAR Robert E. Farkas	
25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy. (21225)			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-61		67 10030		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10030	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
AYERS, MISSOURI F. MISSOURI F. AYERS				10-13-67, 4-35 PM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
LUTHERAN HOSPITAL OF MARYLAND				MARYLAND.		A. & C.	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE.		52-00	
				D. STREET ADDRESS (If rural, give location)			
				3 ELEVENTH AVE.			
5. SEX	6. RACE	7. MARRIED - NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days	
F	W	Widowed		10-22-78	88		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Va		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles H. Rowley JOHN E. AYERS - SON				Susan Marshall			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		---		John E. Ayers - 3 11th Ave.,		Baltimore 21225	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.014-157X				Severe Pulmonary Edema			
(This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Cardiac decompensation			
				(C) Arteriosclerotic heart disease -			
				CA of Janeway			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19-27-67							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9-22-1967 to 10-13-1967, that (I) (we) last saw the deceased alive on 10-13-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Therese B. P. B.				LUTHERAN HOSPITAL OF Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/17/1967		Cedar Hill Cemetery		Ritchie Hwy., A. A. Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 20 1967		Robert E. Talley		George J. Gonce-4001 Ritchie Hwy.,		Baltimore	

CA J. J. Jones
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9-27-21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10031				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10031	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>White Samuel</i>				2. DATE AND HOUR OF DEATH <i>7:15 PM 10/19/67</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>				A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Crownsville State Hosp. Md.</i>			
				D. STREET ADDRESS (If rural, give location) <i>2102 E. Biddle Street</i>			
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>5/1/03</i>		9. AGE (In years, last birthday) <i>64</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unknown</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>		11. BIRTHPLACE (State or foreign country) <i>N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Samuel White</i>				14. MOTHER'S MAIDEN NAME <i>Frances</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Yellie White 2102 E. Biddle St</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>455X I</i>				CAUSE OF DEATH (A) <i>Congestive Heart Failure</i> (B) <i>Atrial Fibrillation</i> (C) <i>Chronic Brain Syndrome</i>		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>8/7/67 8/16/67 9/1/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bilateral supratentorial craniotomy - craniectomy</i>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>9/1/67</i> to <i>10/19/67</i> and that (I) (we) last saw the deceased alive on <i>10/19/67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Jeffrey Steyer</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/19/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>JEFFREY STEYER, M.D.</i>				23D. ADDRESS <i>401 Mt. Hope Hospital Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Oct 23/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cemetery A.A. County Md.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 20 1967</i>		25B. NAME OF REGISTRAR <i>John E. Feltner</i>		25C. FUNERAL DIRECTOR <i>John T. Echeverre</i>		ADDRESS <i>11297 Carle...</i>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10032	
BIRTH NO. 67 10032		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN POLSTON		2. DATE AND HOUR OF DEATH 10-18-67 16:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1009 WEBB COURT - 21202			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/2/93	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME THOMAS POLSTON			14. MOTHER'S MAIDEN NAME GEORGIANNA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-05-0072A		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 773X I RESPIRATORY ARREST PROBABILE PNEUMONIA		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5 min 10 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-1-67 to 10-18-67, that (I) (we) lost saw the deceased alive on 10-18-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert A. Cordes				23B. DATE SIGNED 10-18-67	
23C. PHYSICIAN'S NAME (Type) ROBERT A. CORDES				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct 21 67		24C. NAME of CEMETERY or CREMATORY Arlington Memorial Park	
24D. LOCATION (City, town, or county) Arlington Md		24E. LOCATION (State) Md			
25A. DATE REC'D BY HEALTH DEPT. OCT 20 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Milton E. Hickman 16297 Carolina St	

M-452

67 10033 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10033

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)JOSEPH *Brown Low* Mullins

2. DATE AND HOUR PRONOUNCED DEAD

October 21, 1967 6:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1422 W. Lombard Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

July 22, 1909 58

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MINER

10B. KIND OF BUSINESS OR INDUSTRY

Coal Mining

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

John W. Mullins

14. MOTHER'S MAIDEN NAME

Mary B. Bowling

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

World War II

16. SOCIAL
SECURITY NO.

231-12-8223

17. INFORMANT

HATTIE MULLINS 1422 W. Lombard St.

ADDRESS

18. E 812.7

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Traumatic Injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Carey St. South of Washington Blvd.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

10/16/67 2:25 P.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by bus

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/21/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

10-24-67

23C. NAME of CEMETERY or CREMATORY

Hutchinson's

23D. LOCATION (City, town, or county)

Wise County

(State)

Virginia

24A. DATE REC'D BY HEALTH DEPT.

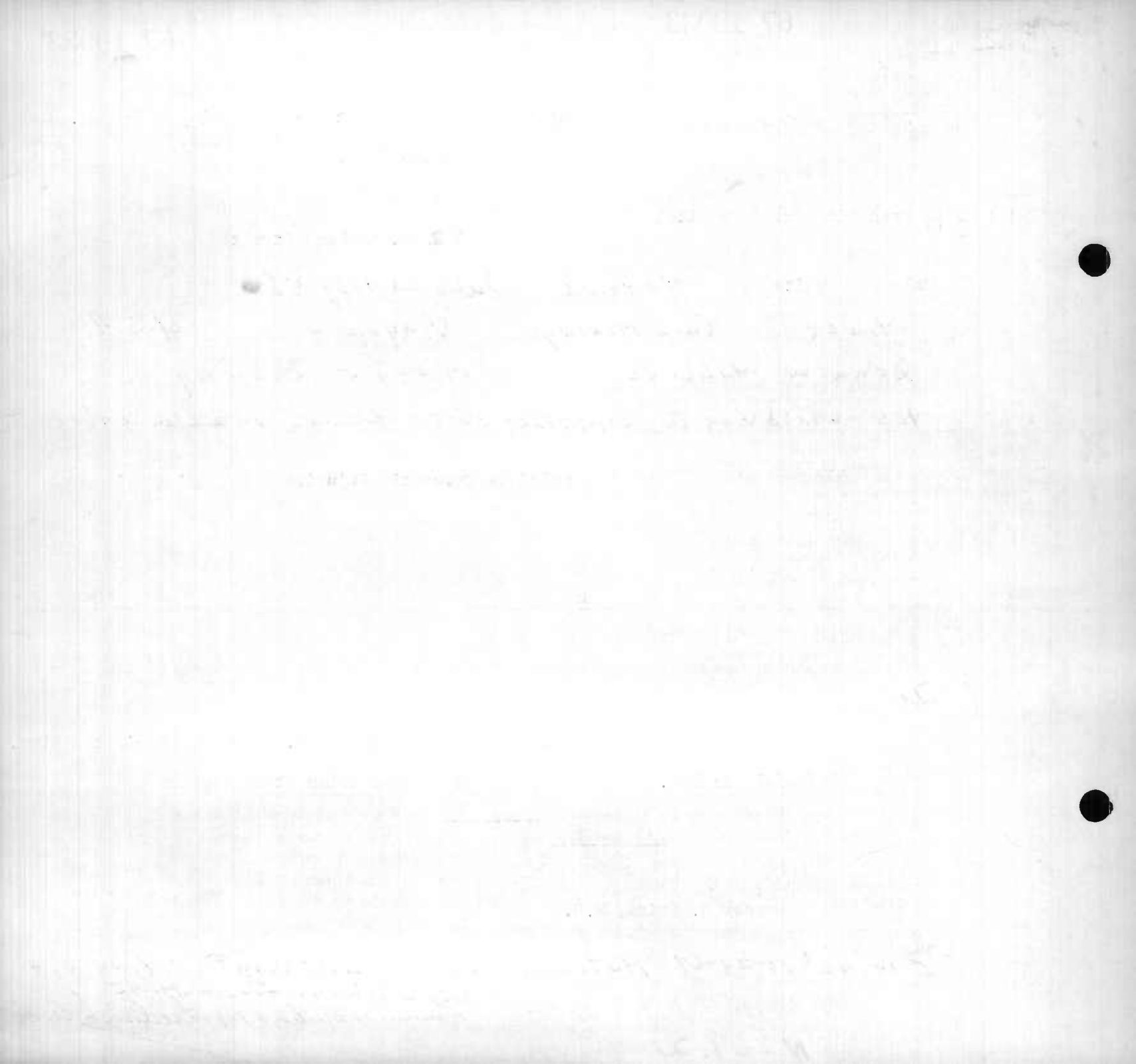
OCT 23 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

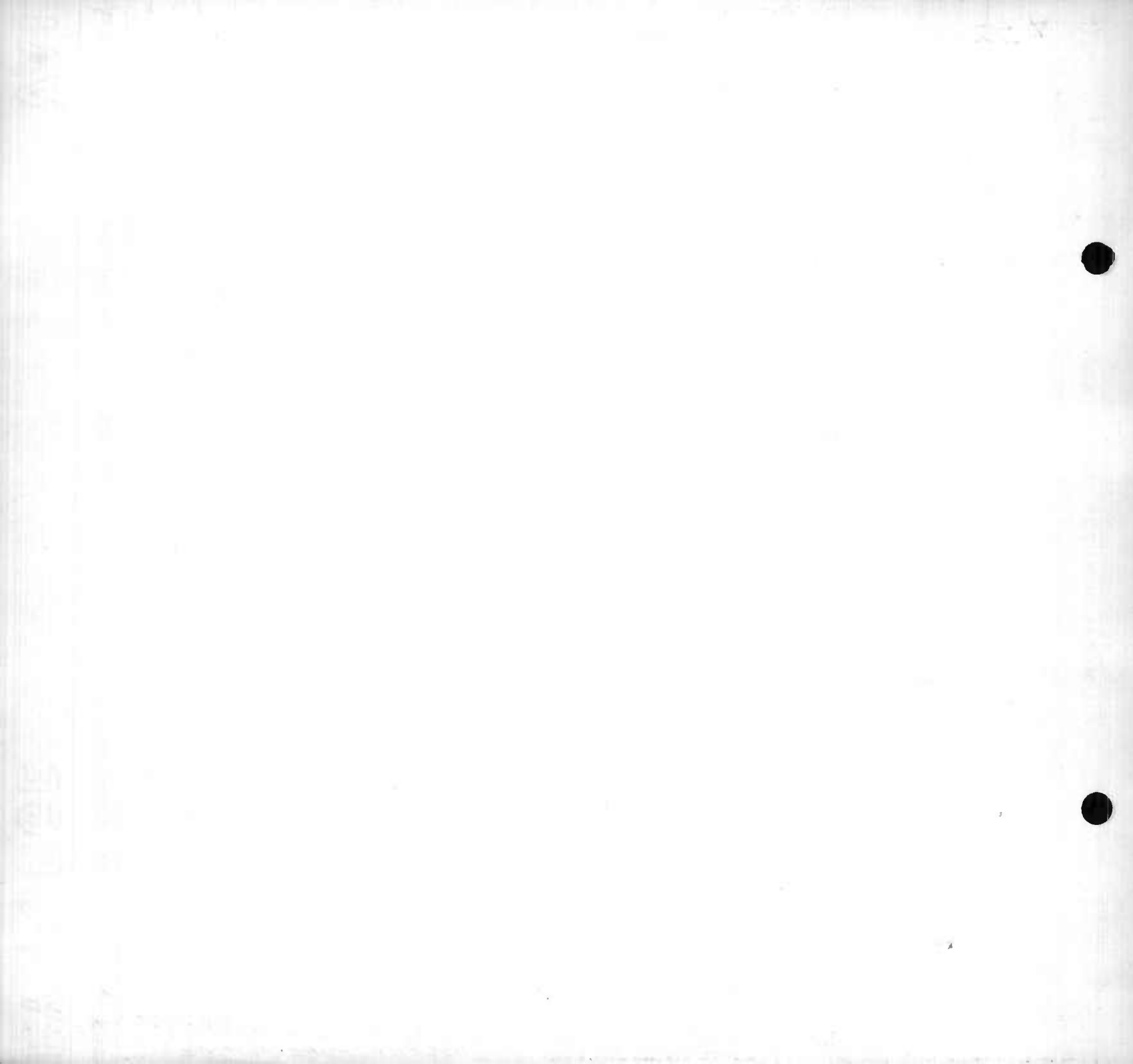
Geo. L. Schwab 2101 Frederick Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

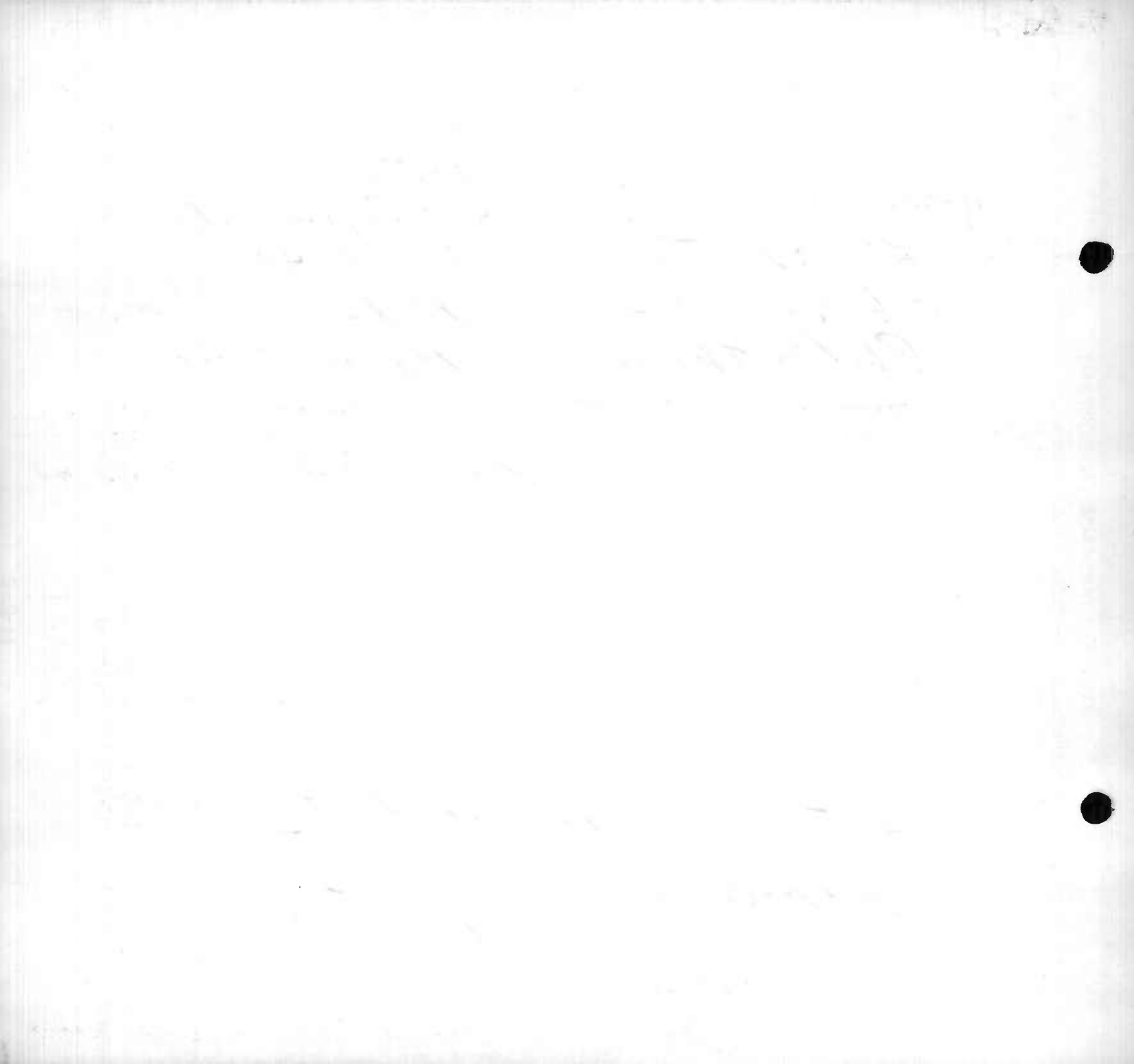
BALTIMORE CITY HEALTH DEPARTMENT				67 10034		Registered No. 67 10034	
BIRTH NO. 67 10034				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>GOLDSCHMIDT, LOUISE S.</u>		2. DATE AND HOUR OF DEATH <u>10-18-1967</u> <u>1.30 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>26-08</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>NORTH CHARLES GENERAL HOSPITAL</u>				D. STREET ADDRESS (If rural, give location) <u>230 S. CONKLING ST.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5-1-1889</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOHN MILLER</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA SCHMIDT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>217-54-3041</u>		17. INFORMANT <u>HOSPITAL'S CHART</u>		ADDRESS
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>CEREBRAL HEMORRHAGE</u> 24h.				INTERVAL BETWEEN ONSET AND DEATH <u>24h.</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASPIRATING PNEUMONIA</u> 24h.				<u>20 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>Oct 17</u> 19 <u>67</u> to <u>Oct 18</u> 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>Oct 18</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Juan F. Aleman</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Oct 18/1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN CONSTANTINI</u> M.D.				23D. ADDRESS <u>234 S. CONKLING ST. BALTIMORE, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/24/67</u>		24C. NAME of CEMETERY or CREMATORY <u>OAK LAWN</u>		24D. LOCATION (City, town, or county) (State) <u>COLGATE MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 23 1967</u>		25B. NAME OF REGISTRAR <u>Albert E. Taylor, MA</u>		25C. FUNERAL DIRECTOR <u>T. Ulrich for E. Aleman</u>		ADDRESS <u>4216 BELAIR</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10035	
BIRTH NO. 67 10035		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Theiss, Paul Hubert</i>		2. DATE AND HOUR OF DEATH <i>10/18/67 8:45 A</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hosp</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>4113 Raymonn Avenue</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>		8. DATE OF BIRTH <i>01/14/18</i>	9. AGE (In years last birthday) <i>49</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cab Driver</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>TAXI CABS</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Philip Theiss</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Fresh</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WW2 6/10/42 - 10/19/43 213-TH 3967</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MRS EDNA THEISS 4113 RAYMONN</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute MI</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <i>W.K.W.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/14/67</i> to <i>10/18/67</i> , that (I) (we) last saw the deceased alive on <i>10/17/67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. H. Holcomb</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10/18/67</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. <i>Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10/21/67</i>		24C. NAME of CEMETERY or CREMATORY <i>LODGE PARK</i>	
24D. LOCATION (City, town, or county) <i>BALTIMORE</i>		24E. STATE <i>MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 23 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>ULLRICH FUNERAL HOME - 4211 BELAIR</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10036
BIRTH NO. 67 10036		CERTIFICATE OF DEATH		
M.E. CASE NO.		1. NAME OF DECEASED J. (middle initial) (Type or Print) Frank Schwartz		
2. DATE AND HOUR OF DEATH 10-19-67 5 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital Wilkins & Caton Aves.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00		
		D. STREET ADDRESS (If rural, give location) 2808 Louisiana Ave. 21227		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5/25/84	9. AGE (In years last birthday) 195 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegrapher		10B. KIND OF BUSINESS OR INDUSTRY B & O - retired		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Schwartz		
14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 705-05-7974		17. INFORMANT ADDRESS James J. Ridgell, 109 S. Longcross Rd. 21090		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.11		CAUSE OF DEATH Arterio Sclerotic Cardiovascular Disease Dehydration Calcemia		INTERVAL BETWEEN ONSET AND DEATH 10 yrs. unknown unknown
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 10/19/67 10/19/67
22. I certify that (I) (this hospital) attended the deceased from 10/19/67 to 10/19/67 and that in (my) 10/19/67 opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.				
23A. SIGNATURE W.E. McCreath		23B. DATE SIGNED 10/20/67		23C. PHYSICIAN'S NAME (Type) W.E. McCreath
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/23/67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery
24D. LOCATION Baltimore		25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967		
25B. NAME OF REGISTRAR Robert E. Falsura		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkins Ave. 21229		

Hydrogen Sulfide (Carbide)
Hydrogen Sulfide
Hydrogen Sulfide
Hydrogen Sulfide

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St. Adams Hosp. 3/10/1914
Chas. M. Galt
Chas. M. Galt
Chas. M. Galt

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>67-20835</u>				67 10037				BALTIMORE CITY HEALTH DEPARTMENT				DR. FLEMING				REGISTERED No. <u>67 10037</u>			
M.E. CASE NO.								CERTIFICATE OF DEATH											
1. NAME OF DECEASED (Type or Print) <u>Daniel DAVIS</u>								2. DATE AND HOUR OF DEATH <u>10-18-67</u> <u>9:10 AM.</u>											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u>								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Glen Burnie</u> <u>52-00</u> D. STREET ADDRESS (If rural, give location) <u>1215 Dorsey Road</u>											
5. SEX <u>male</u>		6. RACE <u>white</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>10-16-67</u>		9. AGE (In years last birthday) <u>55</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Ralph DAVIS</u>								14. MOTHER'S MAIDEN NAME <u>Linda Wallace</u>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MR. Ralph Davis (Father)</u> ADDRESS <u>Some as #4</u>													
18. <u>754.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CONGENITAL HEART DISEASE</u>								INTERVAL BETWEEN ONSET AND DEATH <u>55 hours</u>											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>yes</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?											
22. I certify that (1) <u>(this hospital)</u> attended the deceased from <u>10-16</u> 19 <u>67</u> to <u>10-18</u> 19 <u>67</u> , that (1) <u>(we)</u> last saw the deceased alive on <u>10-18</u> 19 <u>67</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (1) <u>(We)</u> (did) (did not) view the body after death.																			
23A. SIGNATURE <u>GARY A. FLEMING</u>												23B. DATE SIGNED <u>10-18-67</u>							
23C. PHYSICIAN'S NAME (Type) <u>GARY A. FLEMING</u>												23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>OCT 23 1967</u>				24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Mem Park</u>				24D. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 23 1967</u>				25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>				25C. FUNERAL DIRECTOR <u>EB Fleming</u> ADDRESS <u>Singleton Funeral Home Glen Burnie, Md</u>											

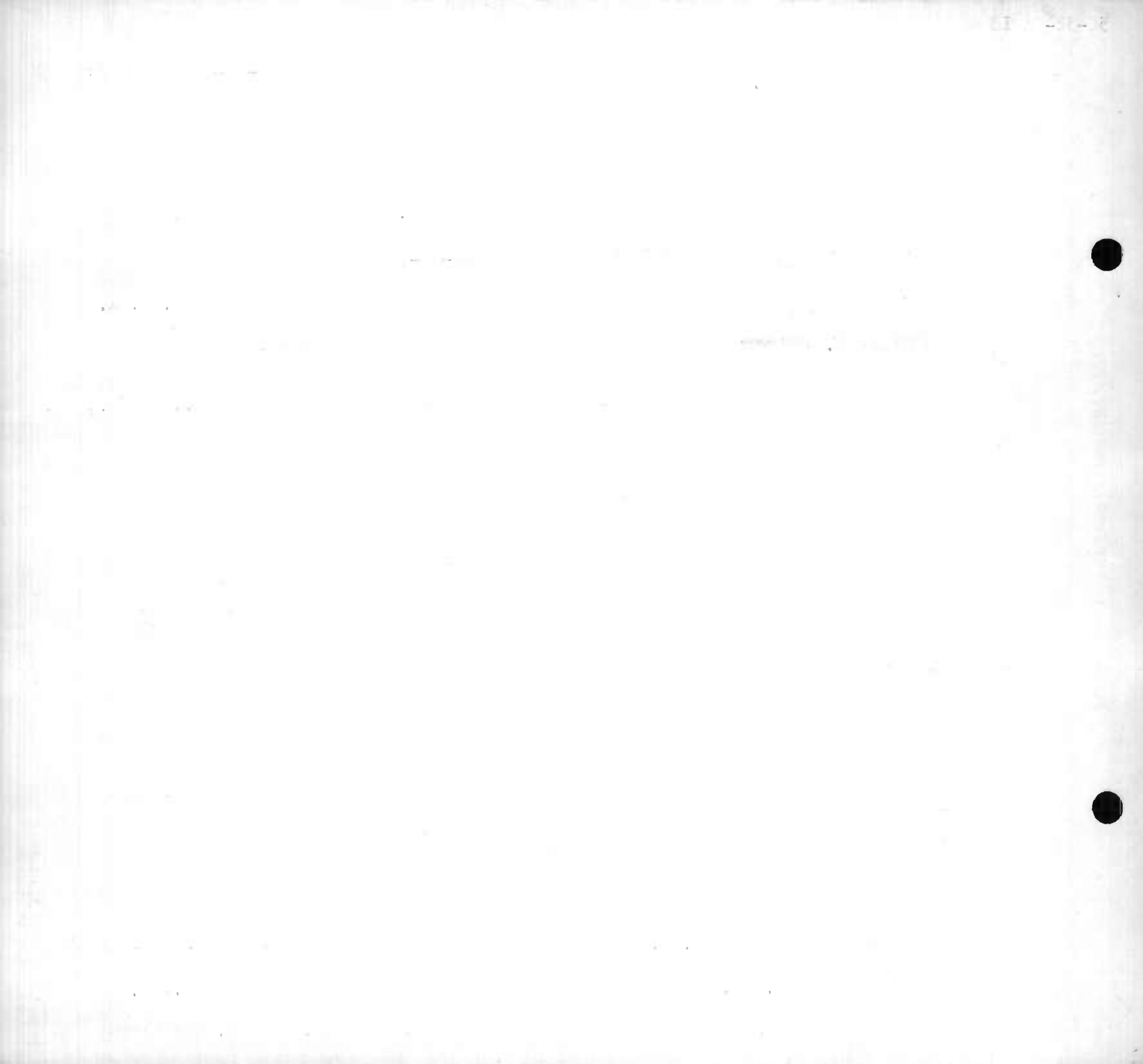
Ande Brundel

No. 11016 No. 11017 and 11018 11019 11020

Barrel
The House of Representatives
The Senate

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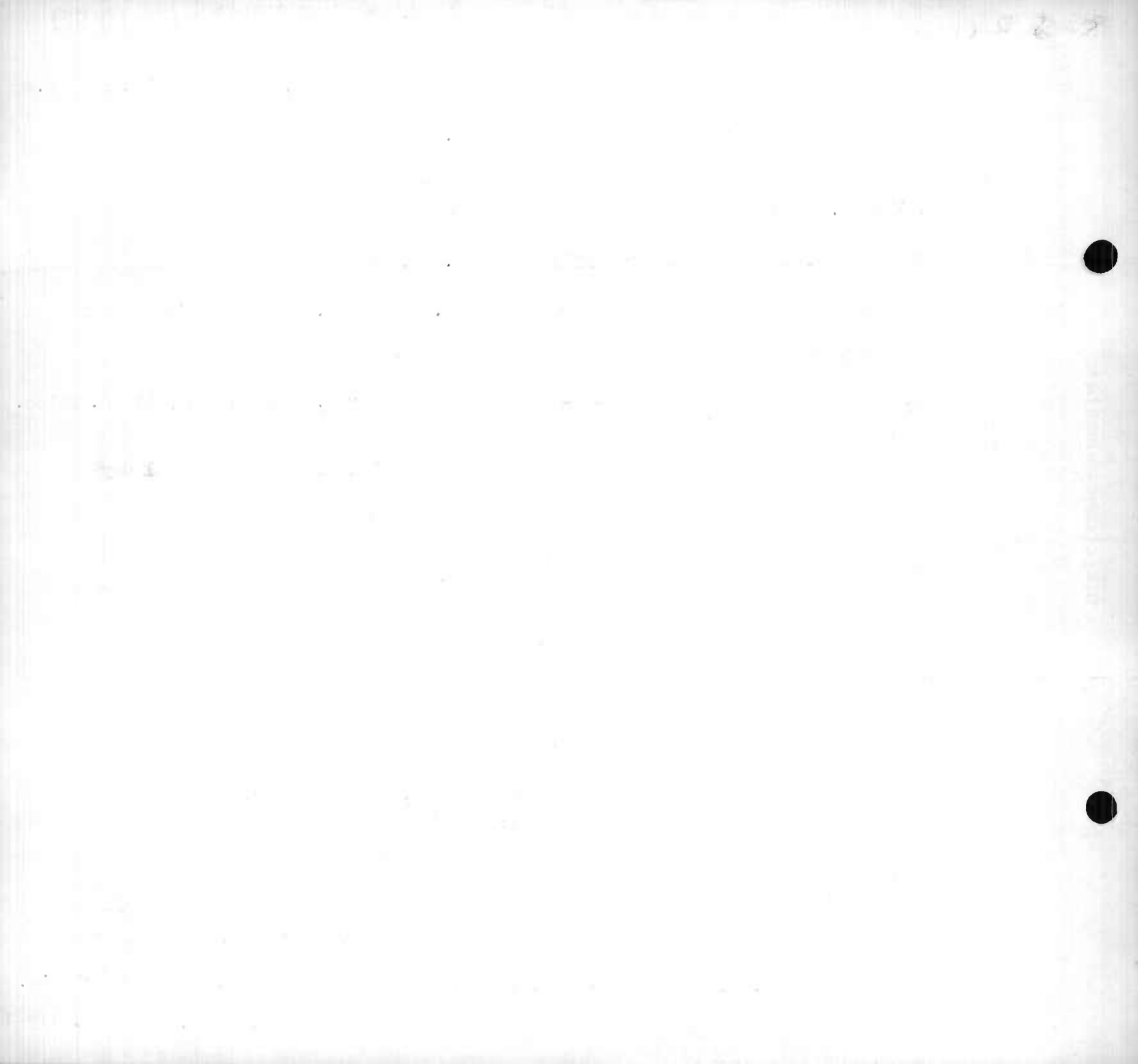
BIRTH NO. H-423		67 10038		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10038	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CLYDE S. HOLSTEIN		2. DATE AND HOUR OF DEATH 18 OCTOBER 1967 3:30 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 31 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2554 W. COLDSRING LANE 21215			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPERATED	8. DATE OF BIRTH 11-29-10	9. AGE (In years lost birthday) 56	10. Under 1 Yr. Months Days Hours Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Molding Machine Operator Plastics Company			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME WILLIAM I. Holstein			14. MOTHER'S MAIDEN NAME ELIZABETH BLANKENSHIP				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 235-01-2278		17. INFORMANT RECORDS: BCH 4940 EASTERN AVE., BALTO., MD.		ADDRESS 21224
18. 722.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH			(A) CIRCULATING ANTICOAGULANT DUE TO AGAINST AHF			INTERVAL BETWEEN ONSET AND DEATH 5 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) PNEUMONIA DUE TO			1 week	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) RHEUMATOID ARTHRITIS			13 years	
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 14 OCTOBER 1967 to 18 OCTOBER 1967 , that (I) was last saw the deceased alive on 18 OCTOBER 1967 and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.							
23A. SIGNATURE Michael R. McMillan M.D.						23B. DATE SIGNED 18 October 1967	
23C. PHYSICIAN'S NAME (Type) MICHAEL McMILLAN M. D.						23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE., BALTO., MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 21, 1967		24C. NAME OF CEMETERY OR CREMATORY Clymalaire Cemetery		24D. LOCATION (City, town, or county) (State) Monkton, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967		25B. NAME OF REGISTRAR Robert E. Farber, MD		25C. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

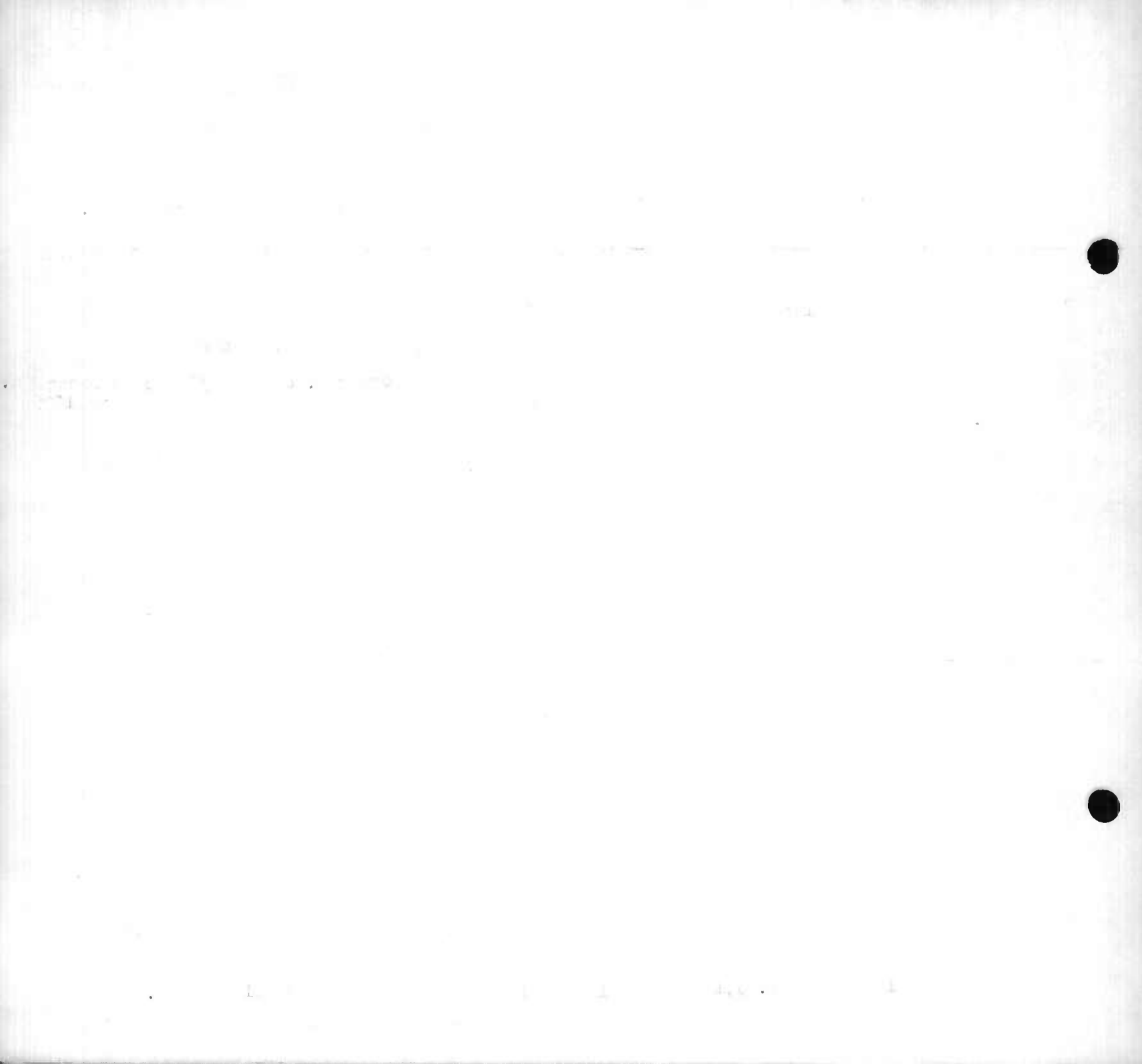
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10039	
BIRTH NO. 67 10039		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Sister Margaret King		2. DATE AND HOUR OF DEATH October 21, 1967 12:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Villa St. Michael		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4000 Forest Hill Road, 21207			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH Oct. 16, 1879	9. AGE (In years last birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Sister of Charity		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	
13. FATHER'S NAME Jeremiah King		14. MOTHER'S MAIDEN NAME Margaret Kelly		12. CITIZEN OF WHAT COUNTRY? United States	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-54-8703		17. INFORMANT ADDRESS Sister Andrea, 4000 Forest Hill Rd. Balto.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 1 day					
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 19, 1960 to October 21, 1967 , that (I) (we) last saw the deceased alive on October 17, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Samuel P. [Signature]</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 3336 Federal Rd. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Oct. 23, 1967	24C. NAME of CEMETERY or CREMATORY Seton Cem. (on grounds of Seton Inst., Reisterstown Rd.)		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS STEWART & MOWEN CO. 108 W. North Av. City 1	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

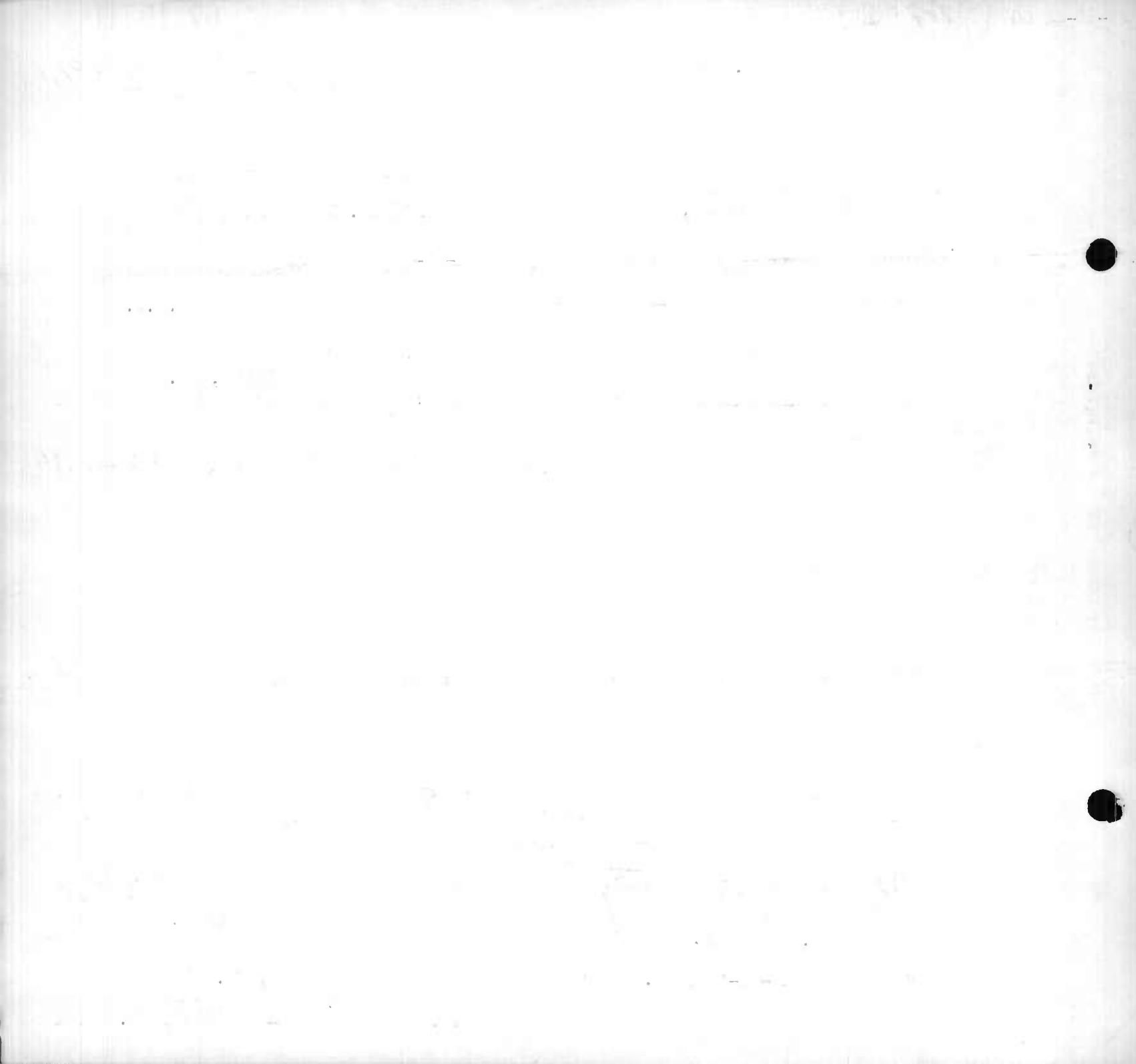
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10040	
BIRTH NO. 67 10040		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Jarrett E. Howard</u>		2. DATE AND HOUR OF DEATH <u>10/20/67</u> <u>2:15a.m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Balt. Co.</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>53-00</u>			
		D. STREET ADDRESS (If rural, give location) <u>Terrace Rd 6030 The Terraces Rd.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>Widowed</u>	8. DATE OF BIRTH <u>02/25/88</u>	9. AGE (In years lost birthday) <u>79</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>? Howard</u>			14. MOTHER'S MAIDEN NAME <u>? Not Known</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-8499</u>		17. INFORMANT <u>Foster S. Howard 6030 The Terraces Rd. Same 21209</u>	
18. <u>420.1 I</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		(A) <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>—</u>			
		(C) <u>—</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William L. Boddie</u>				23B. DATE SIGNED <u>10-20-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>M.D.</u>				23D. ADDRESS <u>Maryland General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Oct. 23, 1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge</u>	
24D. LOCATION <u>Pikesville Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 23 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, MA</u>		25C. FUNERAL DIRECTOR <u>Wm. J. Tackner & Sons N. & Pa. Aves.</u>			



FUNERAL DIRECTOR: IMPORTANT

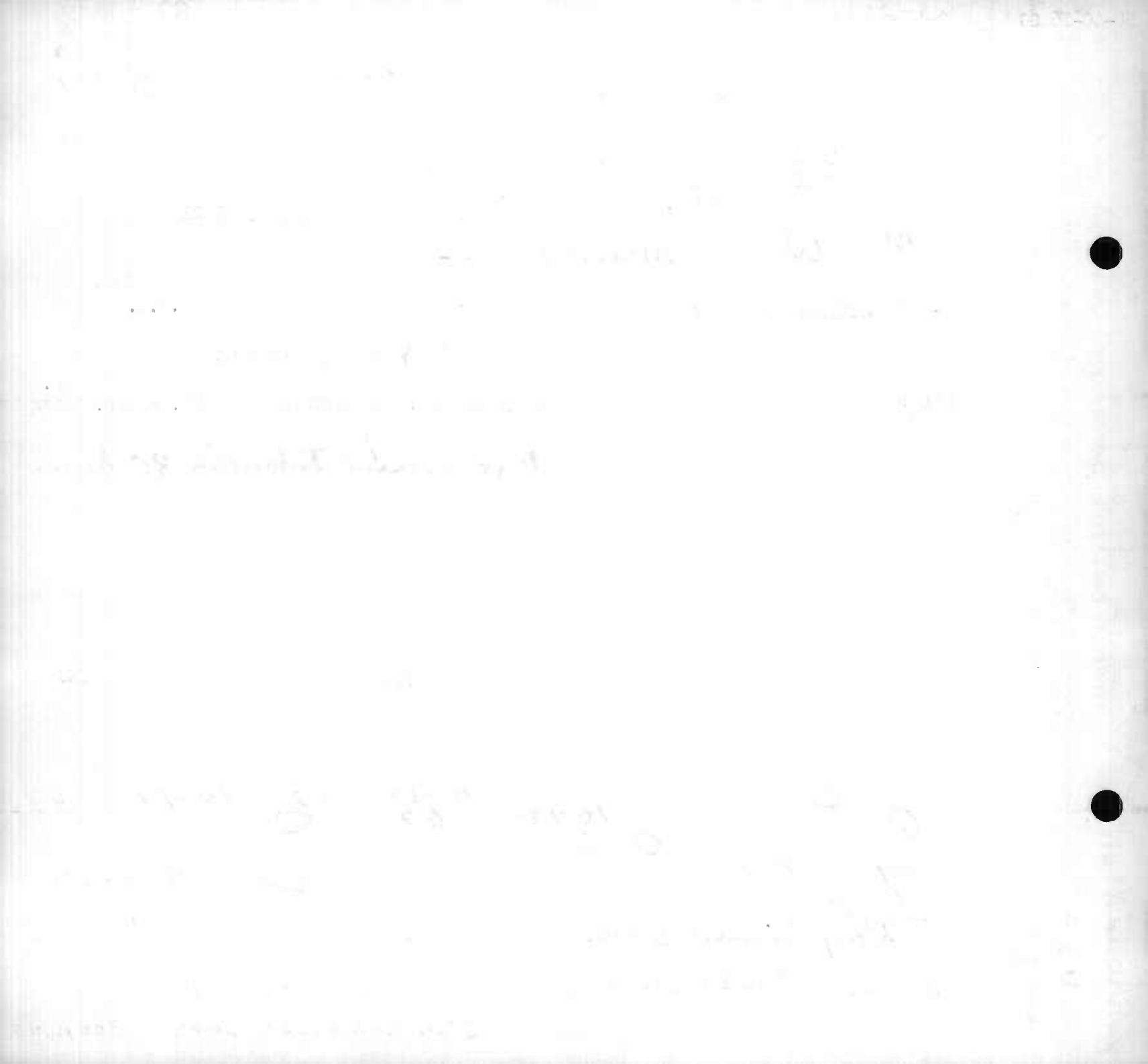
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death				Registered No. 67 10041			
M-630 67 10041				BIRTH NO.							
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Caroline R. Mort</i>				2. DATE AND HOUR OF DEATH <i>10/18/67 12:10 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Frederick Co.</i>							
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>THURMONT</i>							
				D. STREET ADDRESS (If rural, give location) <i>BOX 146 RT. 1 # 21788</i>							
5. SEX <i>FEMALE</i>		6. RACE <i>WHITE</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>SINGLE</i>		8. DATE OF BIRTH <i>10-30-18</i>		9. AGE (In years last birthday) <i>48</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Office Work</i>				10B. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>SPENCER MORT</i>				14. MOTHER'S MAIDEN NAME <i>ETHEL Frushour</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>Not available</i>				17. INFORMANT <i>21224, MD. ADDRESS RECORDS: BCH 4940 EASTERN AVENUE BALTIMORE</i>			
18. <i>176.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>Metastatic Ovarian Carcinoma</i>				CAUSE OF DEATH (A) <i>Metastatic Ovarian Carcinoma</i> DUE TO (B) _____ DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <i>22 months</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>2</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>Yes</i>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from <i>9/19</i> 19 <i>67</i> to <i>10/18</i> 19 <i>67</i> , that we (we) last saw the deceased alive on <i>10/18</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Murray A. Katz</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>10/18/67</i>			
23C. PHYSICIAN'S NAME (Type) <i>DR. MURRAY A. KATZ</i>				M.D. 23D. ADDRESS <i>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>				24B. DATE <i>10-21-1967</i>				24C. NAME OF CEMETERY or CREMATORY <i>St. John's Cemetery</i>			
				24D. LOCATION (City, town, or county) (State) <i>Frederick, Md. 21701</i>							
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 23 1967</i>				25B. NAME OF REGISTRAR <i>Robert E. Farley</i>				25C. FUNERAL DIRECTOR <i>Elwood T. Whitmore</i>			
				ADDRESS <i>M.R. Etchison & Son-Frederick, Md. 21701</i>							



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10042		BALTIMORE CITY RURAL DEPARTMENT		Registered No. 67 10042	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Wayson, Henry F.</i>		2. DATE AND HOUR OF DEATH <i>10-18-67 12:00 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY <i>Balt. Co.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE <i>53-00</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND		D. STREET ADDRESS (If rural, give location) 2017 TRED AVON ROAD # 21221			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH 9-5-19	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LIFT OPERATOR</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AM. CAN CO</i>		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS		14. MOTHER'S MAIDEN NAME CUNIGUNDA GAERIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>UNK</i>		16. SOCIAL SECURITY NO. <i>212-09-4992</i>		17. INFORMANT RECORDS: BCM 4940 EASTERN AVE. BALTO. 21224 MD.	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>30 hours</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <i>10-12-1967</i> to <i>10-18-1967</i> , that (1) (we) lost saw the deceased alive on <i>10-18-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Roy Samuel Weiner</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>10-18-67</i>		23C. PHYSICIAN'S NAME (Type) DR. ROY SAMUEL WEINER <i>Roy Samuel Weiner</i>	
23D. ADDRESS BALTIMORE 21224, MARYLAND BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE <i>10/23/67</i>	
24C. NAME OF CEMETERY OR CREMATORY SACRED HEART		24D. LOCATION BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967	
25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR J.G. CONNELLY SONS		25D. ADDRESS 300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-3010		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10043	
BIRTH NO. 62-30086 67 10043		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ann Sheila FITE		2. DATE AND HOUR OF DEATH 10/16/67 11:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 13-06	
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital of Baltimore Baltimore, Md.		D. STREET ADDRESS (If rural, give location) 1027 W. 37th ST. #11		11. BIRTHPLACE (State or foreign country) Maryland	
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED (specify)	8. DATE OF BIRTH 11/3/62	9. AGE (In years last birthday) 4	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10B. KIND OF BUSINESS OR INDUSTRY —		12. CITIZEN OF WHAT COUNTRY? US.	
13. FATHER'S NAME Allen FITE			14. MOTHER'S MAIDEN NAME Ruth - W. Hairsine		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS Chart - Sinai Hosp. -	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Aspirator Pulmonary non-function		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Brain Stem Glioma					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 10/13/67 19 to 10/16/67 19, that (I) (we) last saw the deceased alive on 10/16/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank Bourger				23B. DATE SIGNED 10/16/67	
23C. PHYSICIAN'S NAME (Type) —				23D. ADDRESS M.D. Sinai Hospital - Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-20-67		24C. NAME OF CEMETERY or CREMATORY Crest Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Howard Co MD		25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Burgee Funeral Home		25D. ADDRESS 3631 Falls Rd	

11/12/01 10:10 AM

8

4

11/12/01

CV

Roots

Chart - 10/12/01

10/12/01 10:10 AM

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10/12/01 10:10 AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-652		67 10044		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10044	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>WASIL SKRENCZUK</u>				10-19-67 4:35 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hosp</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY <u>25-05</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #21226</u>			
				D. STREET ADDRESS (If rural, give location) <u>1608 Cherry St.</u>			
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widower</u>	8. DATE OF BIRTH <u>4-26-1887</u>	9. AGE (In years, last birthday) <u>80</u>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner - Beth Steel</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE - Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family</u>		ADDRESS <u>Same</u>	
18. <u>443 XI</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) <u>Cerebral Hemorrhage</u> DUE TO			
				(B) <u>Hypertension</u> DUE TO			
				(C) <u>Arteriosclerotic Cardiovascular Disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (the) (this hospital) attended the deceased from <u>10-18</u> 19 <u>67</u> to <u>10-19</u> 19 <u>67</u> , that (the) (we) lost saw the deceased alive on <u>10-19</u> 19 <u>67</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Arnold M. Wood</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10-20-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Donald M. Wood</u> M.D.				23D. ADDRESS <u>1213 Light St.</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-23-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Trinity R.C. Ort. Cem</u>		24D. LOCATION (City, town, or county) (State) <u>ELKridge, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 23 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairley</u>		25C. FUNERAL DIRECTOR <u>John H. Hahn</u> ADDRESS <u>4200 Pennsylvania Ave. Bk 170. 21226, Md.</u>			



1
R-163

67 10045

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10045

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN J. ROBERTSON

2. DATE AND HOUR PRONOUNCED DEAD

October 19, 1967

11:16 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Brooklyn

D. STREET ADDRESS (If rural, give location)

1004 Jack Place

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 29, 1940

9. AGE (In years
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Plumber

10B. KIND OF BUSINESS OR INDUSTRY

Plumbing

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert Robertson

14. MOTHER'S MAIDEN NAME

Josephine Twigg

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Leona Robertson

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cardiac tamponade
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Laceration of heart
DUE TO

(C) Impact to chest

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Frankfurt east of 2nd Street 52-00

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

10-19-67

10:50 P.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Driver of panel-
truck that ran into telephone pole.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 20, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10 23 67

23C. NAME of CEMETERY or CREMATORY

Holy Cross

23D. LOCATION

(City, town, or county)

Brooklyn, A. A. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 23 1967

24B. NAME OF REGISTRAR

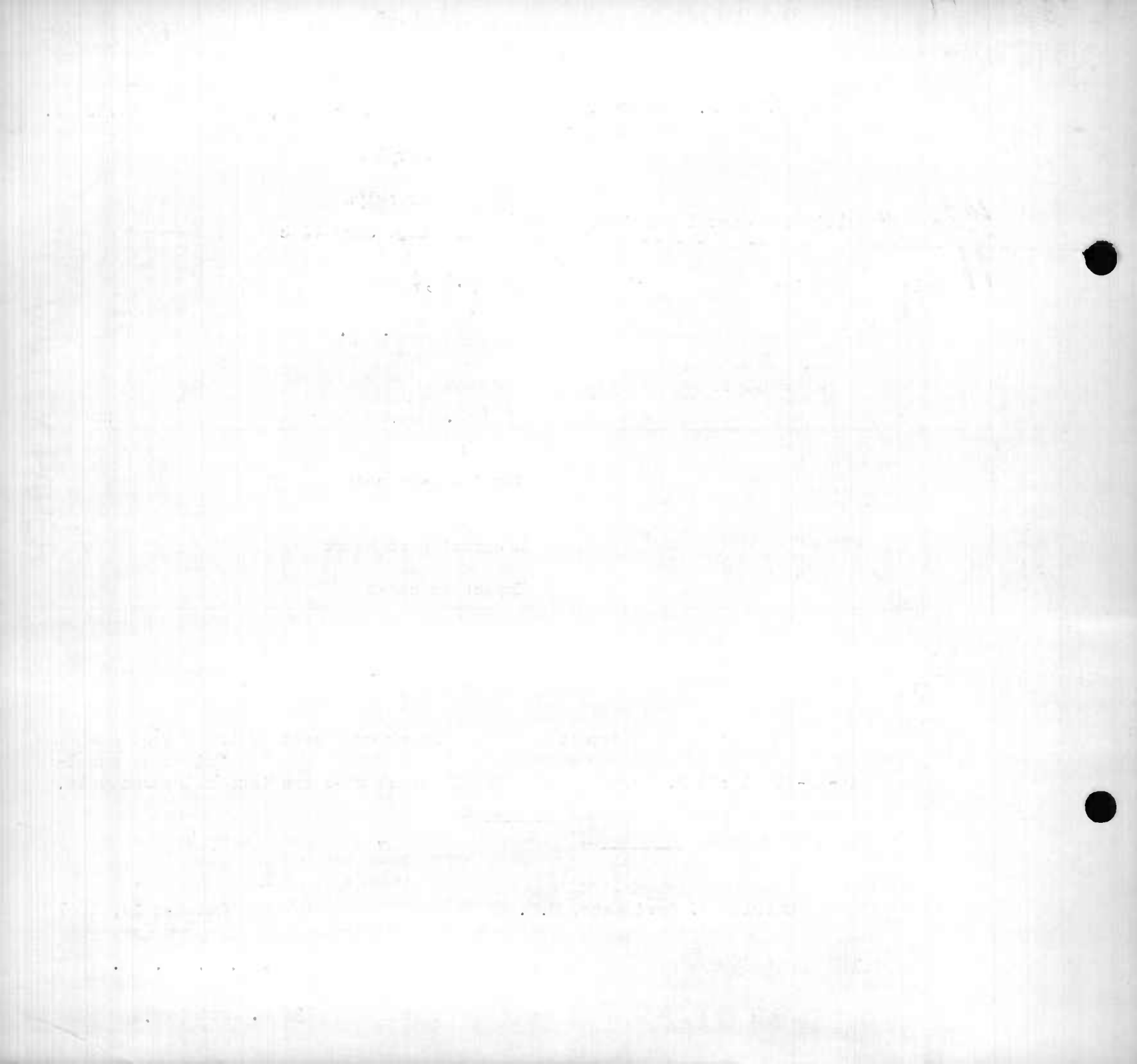
Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Mc Gully

ADDRESS

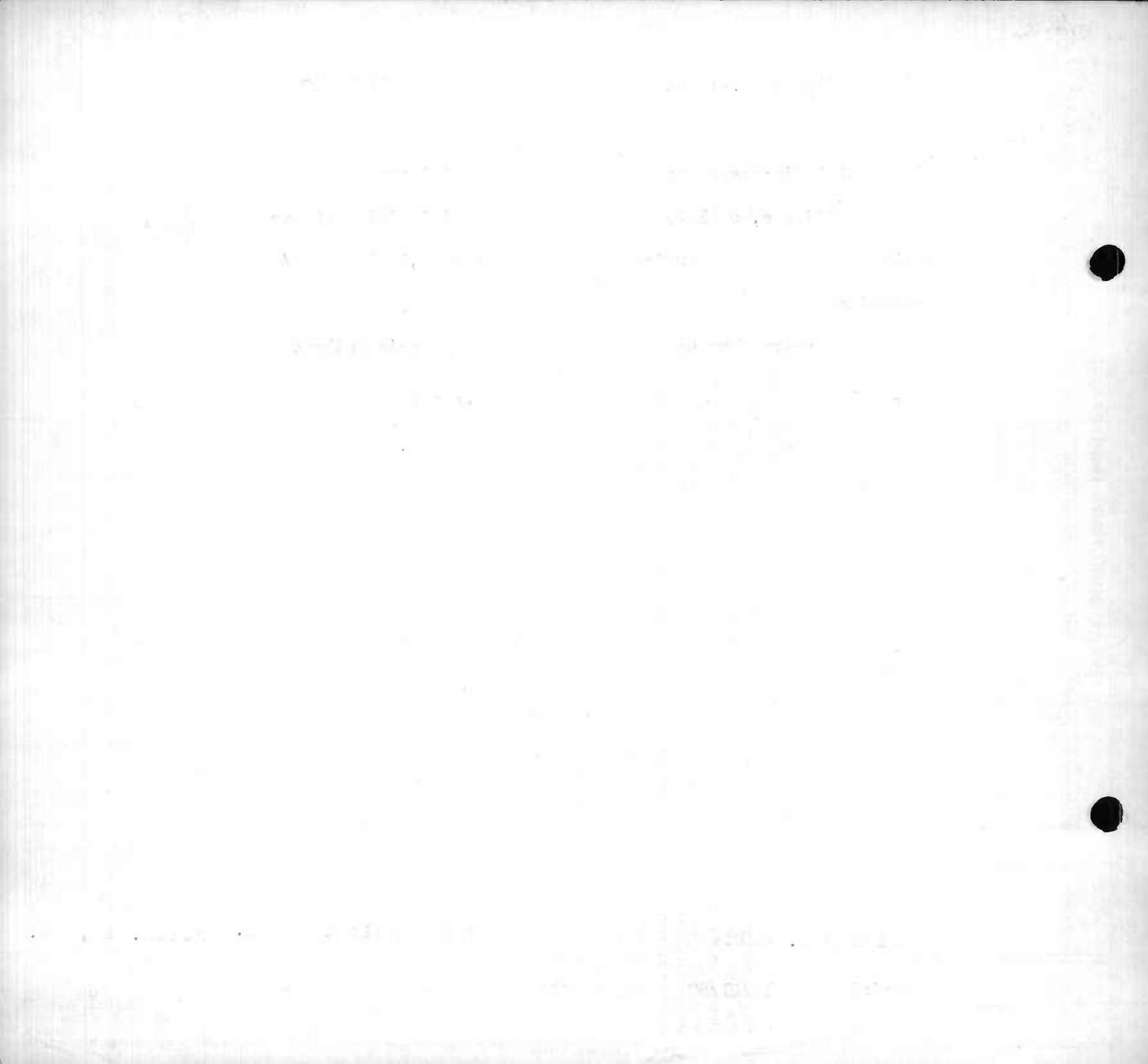
130 E. Fort Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10946		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10046	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Emily M Everhart			2. DATE AND HOUR OF DEATH 10/19/67		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4102 Hillcrest Ave Baltimore, Md 21225			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4102 Hillcrest Ave		
5. SEX Female	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept 18, 1903	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N Y	
13. FATHER'S NAME Henry Hausman			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Family ADDRESS Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the immediate cause of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of breast with metastasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Pulmonary tuberculosis			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO 2 years.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary tuberculosis			INTERVAL BETWEEN ONSET AND DEATH 3 6 weeks		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 17 to Oct 19 19 67 , that (I) (we) last saw the deceased alive on Oct 17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sidney R. Gehlert				23B. DATE SIGNED 10/19/67	
23C. PHYSICIAN'S NAME (Type) Sidney R. Gehlert				23D. ADDRESS 4700 Pennington Ave. Balto. 26, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/21/67		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem	
24D. LOCATION A A Co		24E. STATE Md		24F. CITY, TOWN, or county	
25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR McCurly F.H. 737-4444	
25D. ADDRESS 21225					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10047	
BIRTH NO. 67 10047					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Henry Knickerbocker			2. DATE AND HOUR OF DEATH Oct 19, 1967 12 45 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY BALTO. Balt. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) CATONSVILLE 53-00 D. STREET ADDRESS (If rural, give location) 2 Edmonds Ridge Rd. #26		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/11/05	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Ooys If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPERRY RAND CO		10B. KIND OF BUSINESS OR INDUSTRY RET.	11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME FRED KNICKERBOCKER			14. MOTHER'S MAIDEN NAME MARY CASE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 095 10 8137	17. INFORMANT HOSPITAL RECORDS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Myocardial Infarction 1 hr (B) Atherosclerotic Cardiovascular Disease 10 yrs. (C)		
INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 19 1967 to Oct 19 1967, that (I) (we) last saw the deceased alive on Oct 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. P. Weinfeld			23B. DATE SIGNED Oct 19, 67		
23C. PHYSICIAN'S NAME (Type) Andrew P. Weinfeld			23D. ADDRESS The Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/23/67		24C. NAME OF CEMETERY OR CREMATORY EVERGREEN	
24D. LOCATION PINE PLAINS, N.Y.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967		25B. NAME OF REGISTRAR E. S. MALNAB		25C. FUNERAL DIRECTOR 301 FREDERICK RD 21228	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10048

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)
JAMES

W.

JONES

2. DATE AND HOUR PRONOUNCED DEAD

October 16, 1967 | 8:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1000 Parksley St.

FULL NAME OF
HOSPITAL OR
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1000 Parksley Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 8, 1888

9. AGE (In years
last birthday)

78 yrs.

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

Md. Drydock

11. BIRTHPLACE (State or foreign country)

Saluda South Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John J. Jones

14. MOTHER'S MAIDEN NAME

Rosanah Hartzoge

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL
SECURITY NO.

216-01-0367

17. INFORMANT

ADDRESS

Anna Jones 1000 Parksley Ave. 21223

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
m. WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/16/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Oct. 20, 1967 Glen Haven Cem.

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Ritchie Highway Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

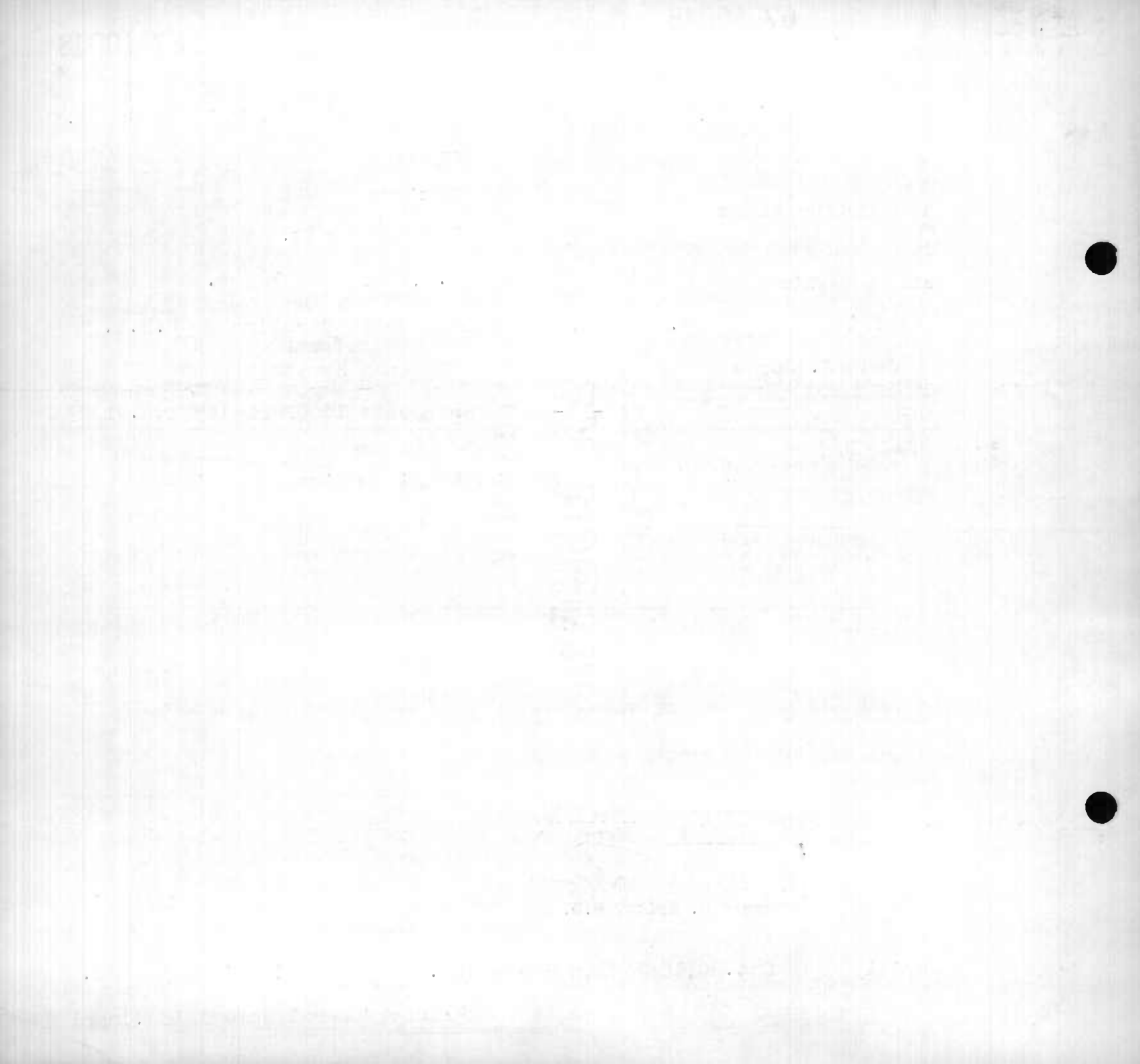
24C. FUNERAL DIRECTOR

ADDRESS

OCT 23 1967

Robert E. Farkas

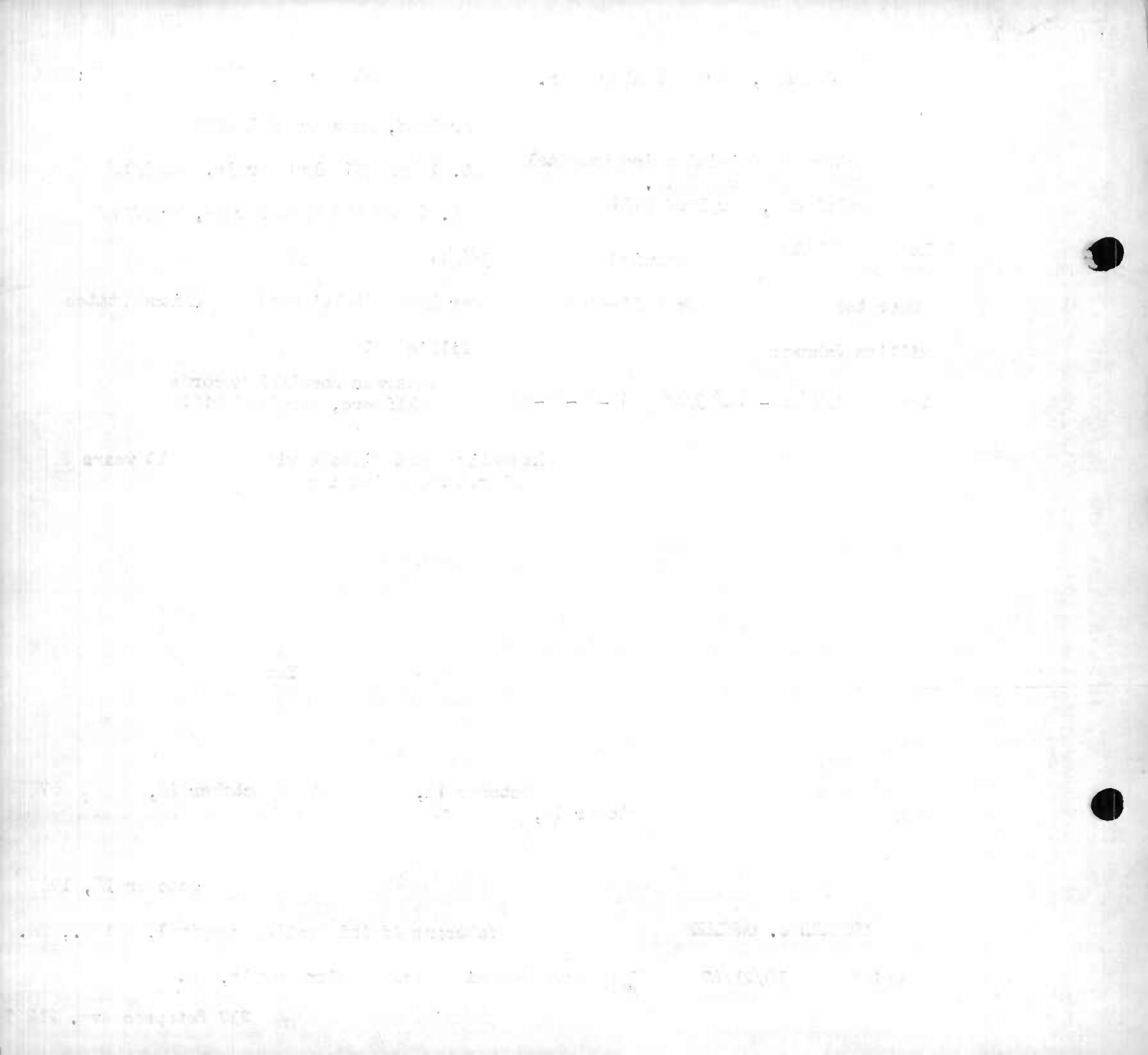
Krause Funeral Home 1216 S. Charles



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10049				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10049	
1. NAME OF DECEASED (Type or Print) Johnson, Vernon Lester Sr.				2. DATE AND HOUR OF DEATH October 18, 1967		12:22 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, B. COUNTY Anne Arundel County			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rt. 1 Box 271 Glen Burnie, Maryland 52-00			
				D. STREET ADDRESS (If rural, give location) Rt. 1 Box 271 Glen Burnie, Maryland			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5/6/11	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10B. KIND OF BUSINESS OR INDUSTRY Book Binding		11. BIRTHPLACE (State or foreign country) Maryland (Baltimore)		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME William Johnson				14. MOTHER'S MAIDEN NAME Tillie ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4/7/44 - 12/23/45		16. SOCIAL SECURITY NO. 212-09-37-90		17. INFORMANT Veterans Hospital Records Baltimore, Maryland 21218		ADDRESS	
18. 410X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Rheumatic Heart Disease with mitral regurgitation DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 13, 1967 to October 18, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 18, 1967 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) did not view the body after death.							
23A. SIGNATURE <i>Richard J. Owellen</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED October 18, 1967		
23C. PHYSICIAN'S NAME (Type) RICHARD J. OWELLEN					23D. ADDRESS M.D. Veterans Administration Hospital, Balto., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/21/67		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967		25B. NAME OF REGISTRAR <i>R. E. Farkner</i>		25C. FUNERAL DIRECTOR <i>McCully Funeral Home</i>			
ADDRESS 237 Patapsco Ave. 21225							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10050		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 10050	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William SCHIFFLER		2. DATE AND HOUR OF DEATH 10/17/67 1045 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE - MD B. COUNTY BALT		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT. 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION Memorial Hosp.		D. STREET ADDRESS (If rural, give location) 521 Elmwood Rd.			
5. SEX M	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/10/05	9. AGE (In years last birthday) 62	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing		10B. KIND OF BUSINESS OR INDUSTRY U.S. Printing		11. BIRTHPLACE (State or foreign country) Md. Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Schiffler		14. MOTHER'S MAIDEN NAME MARY HARRIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-9670		17. INFORMANT PATIENT - SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Pulmonary embolism (B) DUE TO Localized peritonitis (C) DUE TO Cholecystitis W.K. Wu		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 10/9/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/3 19 67 to 10/17 19 67, that (I) (we) last saw the deceased alive on 10/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert P. Doyle		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/17/67	
23C. PHYSICIAN'S NAME (Type) ROBERT P. DOYLE M.D.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-21-1967		24C. NAME OF CEMETERY or CREMATORY Immanuel Lutheran Cem.	
24D. LOCATION Baltimore City Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Laasohn Funeral Home 740 Belair Road			

AL 1960-10-17

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

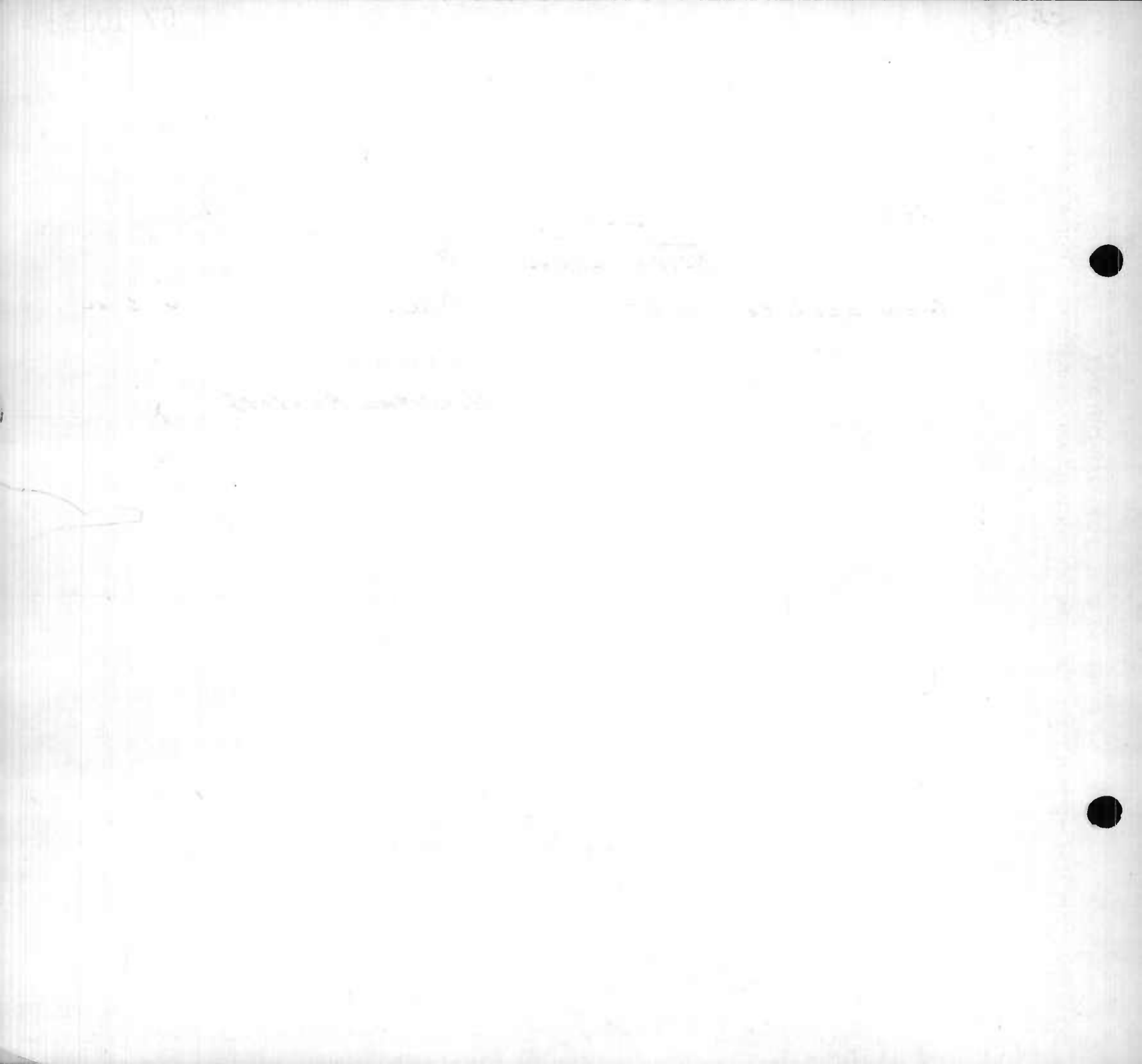
BIRTH NO. 67 10051				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10051	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				SA LGANIK - RPOBYS. MORRIS SALGANIK		10/16/67 11 AM. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
SINAI HOSPITAL				MARYLAND			
42				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
D. STREET ADDRESS (If rural, give location)				4601 PALL MALL ROAD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. UNDER 1 Yr. Months	10. UNDER 24 Hrs. Days	10. UNDER 24 Hrs. Hours
MALE	WHITE	WIDOWED	JANUARY 1, 1890	88 77			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SALESMAN		MEAT BROKER		RUSSIA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNKNOWN				UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		215-01-4482		MR. DAVID SALGANIK, 3210 BONNIE ROAD #21208			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				10/15/67 10/16			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				MYOCARDIAL INSUFFICIENCY			
ANTECEDENT CAUSES				ASCVD			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CHRONIC PULMONARY DISEASE			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/16/67 to 10/16/67 that (I) (we) last saw the deceased alive on 10/16/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
10/16/67						10/16/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
		M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		10-18-67		SHAAREI ZION		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
OCT 23 1967		Robert E. Farley		SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

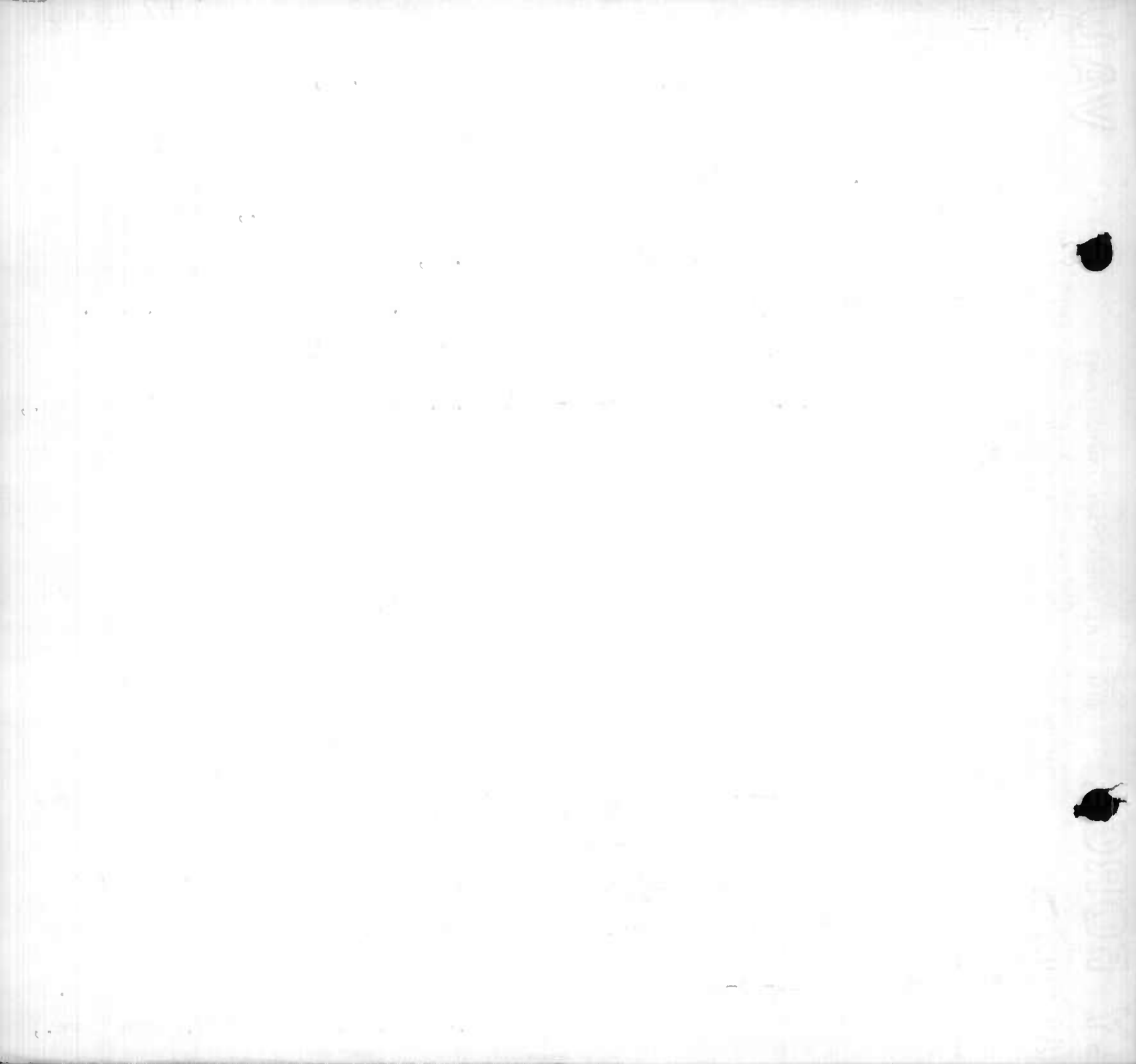
BALTIMORE CITY HEALTH DEPARTMENT				67 10052		67 10052	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				DELAT FRANCES MARY		10-21-67, 11-50 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
LUTHERAN HOSPITAL OF MD 46				MARYLAND - 21228. Balt. Co.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				309-INGLESIDE AVENUE.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days Hours Min.	
F	W	NEVER MARRIED		6-16-'90	77 Yrs.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
GEN. ELEC. CO		RET.		MD.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNKNOWN				UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				HOSPITAL RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443N				(A) M.C.V.D.			
				DUE TO			
				POSS. CEREBRAL HAEMORRHAGE			
ANTECEDENT CAUSES				(B) A.S.C.V.D., ATRIAL FIBRILLATION			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO			
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that, (I) (this hospital) attended the deceased from 10/11 to 10/21 1967, that (I) (we) last saw the deceased alive on 10/21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
DR. THANKAM B. PILLAI							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DR. THANKAM B. PILLAI				LUTHERAN HOSPITAL OF MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		10/24/67		HOLY REDEEMER		BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 23 1967		Robert E. Taylor		E.S. MACNABB		301 FREDERICK RD 21228	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 10053		67 10053	
BIRTH NO.				M.E. CASE NO.		1. NAME OF DECEASED	
(Type or Print)				2. DATE AND HOUR OF DEATH		Registered No.	
Chester B. Simmons				Oct. 20, 1967		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
40 St. Agnes Hospital				Maryland Baltimore Co.			
5. SEX				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
Male				Woodlawn 33-00			
6. RACE				D. STREET ADDRESS (If rural, give location)			
White				5417 Clifton Ave., #07			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
Married				Mar. 23, 1906			
9. AGE (In years lost birthday)				10. CITIZEN OF WHAT COUNTRY?			
61				U. S. A.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Construction Engineer				Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Simmons				Clara Galvin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
yes W.W.2				215-05-0734			
17. INFORMANT				ADDRESS			
Mrs. A. Elsie Simmons				5417 Clifton Ave.,			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				Death coronary occlusion			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Cardio vascular renal disease			
II				(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Hypertension			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
19				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				1950 19 10/20 1967			
22. I certify that (I) (the hospital) attended the deceased from 1950 19 10/20 1967 that (I) (we) last saw the deceased alive on 10/16 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE			
H.W. SCHEYE MD				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
H.W. SCHEYE MD				710 PARK AVE BALTO MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				10-23-1967			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Woodlawn				Woodlawn Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
OCT 23 1967				G. Howard Strong 3207 W. North Ave.,			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10054
BIRTH NO. 67 10054		CERTIFICATE OF DEATH		
M.E. CASE NO. Mitchell, Robert J.		1. NAME OF DECEASED (Type or Print) MA Bon Secours Hospital		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH 10/21/67 12 40 pm M.		
FULL NAME OF HOSPITAL OR INSTITUTION 34		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY Balto.		
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-38		
		D. STREET ADDRESS (If rural, give location) 5815 Chinguapin Pkwy.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9/5/91	9. AGE (In years lost birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Broker		10B. KIND OF BUSINESS OR INDUSTRY Banking	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Mitchell		14. MOTHER'S M maiden name Anne Ross		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Leona B. Mitchell 5815 Chinguapin Pr	
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Encephalomalacia with cerebral arteriosclerosis (B) Generalized arteriosclerosis (C)		INTERVAL BETWEEN ONSET AND DEATH years years
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7-31 19 67 to 10-21 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE Byung Kap Kang				23B. DATE SIGNED 10-21-67
23C. PHYSICIAN'S NAME (Type) BYUNG KAP KANG		23D. ADDRESS Bon Secours Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-24-1967	24C. NAME of CEMETERY or CREMATORY Druid Ridge	24D. LOCATION (City, town, or county) (State) Pikesville Md.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR G. Howard Strong	25C. FUNERAL DIRECTOR ADDRESS 3207 W. North Ave.,	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10055	
BIRTH NO. 67 10055		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Julia Sermons		2. DATE AND HOUR OF DEATH 10-19-67 9:30 P.M. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 10-01	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Little Sisters of the Poor 1200 Valley St., 21202		D. STREET ADDRESS (If rural, give location) 1200 Valley St., 67 10055			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 7-6-1894	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME George W. Sermons		14. MOTHER'S MAIDEN NAME Louise Bartholmeus	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-07-4064A		17. INFORMANT ADDRESS Little Sisters of the Poor	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153-8 I Terminal Ca of the colon		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1966 to Oct. 19 1967, that (I) (we) last saw the deceased alive on Oct 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Stanley Ankudas		23B. DATE SIGNED 10.21.67		23C. PHYSICIAN'S NAME (Type) Stanley Ankudas	
23D. ADDRESS M.D. 1101 Maiden Choice Lane Balt. Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/23/67	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) Baltimore		(State)	
25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967		25B. NAME OF REC'D BY Philip Hering		25C. FUNERAL DIRECTOR Philip Hering	
25D. ADDRESS 2024					

James M. Smith
of the

Oct 10 1850

James M. Smith

James M. Smith
of the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10056		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 10056	
1. NAME OF DECEASED (Type or Print) LILLY E. BYRNE			2. DATE AND HOUR OF DEATH 10-17-67 6:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LITTLE SISTERS OF THE POOR 90 1200 VALLEY STREET BALTIMORE, MARYLAND 21202			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1200 VALLEY STREET		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED (WIDOWED) DIVORCED (specify)	8. DATE OF BIRTH 2-18-85	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME JOHN E. KING			14. MOTHER'S MAIDEN NAME MARY CATHERINE BALL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-09-8094D		17. INFORMANT ADDRESS 1200 VALLEY ST. BALT, MD. LITTLE SISTERS OF THE POOR	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 260 X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO Pulmonary edema Q. S. C. V. D. (B) DUE TO Diabetes mellitus (C) —		
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1966 to Oct 17, 1967 , that (I) (we) last saw the deceased alive on Oct. 17, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley Ankudas			23B. DATE SIGNED 10.19.67		
23C. PHYSICIAN'S NAME (Type) STANLEY ANKUDAS M.D.			23D. ADDRESS 1101 MAIDEN CHOICE LANE BALTIMORE MD.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE Oct 20/67		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
24D. LOCATION Baltimore		24E. DATE REC'D BY HEALTH DEPT. OCT 23 1967		24F. NAME OF REGISTRAR R. E. F. F. F.	
24G. FUNERAL DIRECTOR Philip's Herwig Sons		24H. ADDRESS 2024 Calhoun St			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-2057 67 10057				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10057 4	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				BABY BOY SIMS		10 - 10 1967 4:15 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
34 BON SECOURS HOSP				Md 2TH Vine St. BALTO MD 23			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		20-02	
				D. STREET ADDRESS (If rural, give location)		211 Vine St	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
M	N		10-8-67		2	11	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				MARIAND		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
?				BEVERLY SIMS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				HOSPITAL RECD			
18. 761.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		SEPSIS	
ANTECEDENT CAUSES				(B) DUE TO		MEMBRANES RUPTURED 22 HRS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				PREMATURITY			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 10-8-67 to 10-10-67, that (I) (we) last saw the deceased alive on 10-19-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
FLEHYDE A. NELOCOTON						10-10-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
FLEHYDE A. NELOCOTON		BON SECOURS HOSP.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/20/67		Staten Cen		BALTO MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 23 1967		Robert E. Fairbank		Thomas J. Kenney Inc		BALTO MD	

James M. Smith
1847

James M. Smith
1847

James M. Smith

James M. Smith
1847

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10058				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10058	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Joseph Dennis Beattie		Oct. 18 1967 11:26 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Md.			
US Public Health Service Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
3100 Wyman Park Drive				Baltimore			
D. STREET ADDRESS (If rural, give location)				132 N. Potomac Street			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 2/27/05	
9. AGE (In years lost birthday) 62		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oiler		10B. KIND OF BUSINESS OR INDUSTRY Seafaring		11. BIRTHPLACE (State or foreign country) Del.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John L. Beattie		14. MOTHER'S MAIDEN NAME Catherine Harkins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 207-03-2533		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Obstructive jaundice (A) DUE TO				4 mos.			
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma head of pancreas (B) DUE TO				? ? 4 mos.			
III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Status post Whipple's procedure (C) DUE TO				2 days			
Coagulation deficit				2 days			
19A. DATE OF OPERATION 10/17/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of pancreas		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct. 1 19 67 to Oct. 18 19 67, that (I) (we) last saw the deceased alive on Oct. 18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.							
23A. SIGNATURE Seana Hirschfeld MD.						23B. DATE SIGNED 10/19/67	
23C. PHYSICIAN'S NAME (Type) Seana Q. Hirschfeld, MD.						23D. ADDRESS M.D. US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/21/67		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967		25B. NAME OF REGISTRAR J. J. J. J.		25C. FUNERAL DIRECTOR Joseph N. J. J.		ADDRESS 263 J. J.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10059		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10059	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Johnson Emanuel Jr		2. DATE AND HOUR OF DEATH 10-19-1967 11 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital 11-1-67		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 16-06		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21216	
D. STREET ADDRESS (If rural, give location) 917 Franklinton Road		5. SEX M		6. RACE C	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M		8. DATE OF BIRTH 11/13/24		9. AGE (In years last birthday) 43	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) upholstery		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Johnson Emanuel		14. MOTHER'S MAIDEN NAME Ida A. Pinder	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes War #4		16. SOCIAL SECURITY NO. 215-18-6381		17. INFORMANT Daughter - same.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 10-19-1967 to 10-19-1967		that (I) (we) last saw the deceased alive on 10-19-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE A. N. Turkman M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10-19-67		23C. PHYSICIAN'S NAME (Type) A. N. Turkman M.D.	
23D. ADDRESS Lutheran Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-25-67	
24C. NAME of CEMETERY or CREMATORY Balto. State Carver Mng. Co.		24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Edison Wilson		25D. ADDRESS 1913 W. Balto. St.	

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

FREDERICK

DORSEY

2. DATE AND HOUR PRONOUNCED DEAD

October 21, 1967

10:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1707 W. Calvert Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

6/20/43

9. AGE (In years
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Dorsey

14. MOTHER'S MAIDEN NAME

May Park

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

May Dorsey 1707 N. Calvert St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)Exsanguination due to Gunshot Wound
of Chest involving the aorta and
both lungs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home of Friend

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

850 W. Fairmount Avenue

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

10/21/67 10:00 P.M.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot during argument

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/22/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/25/67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

OCT 23 1967

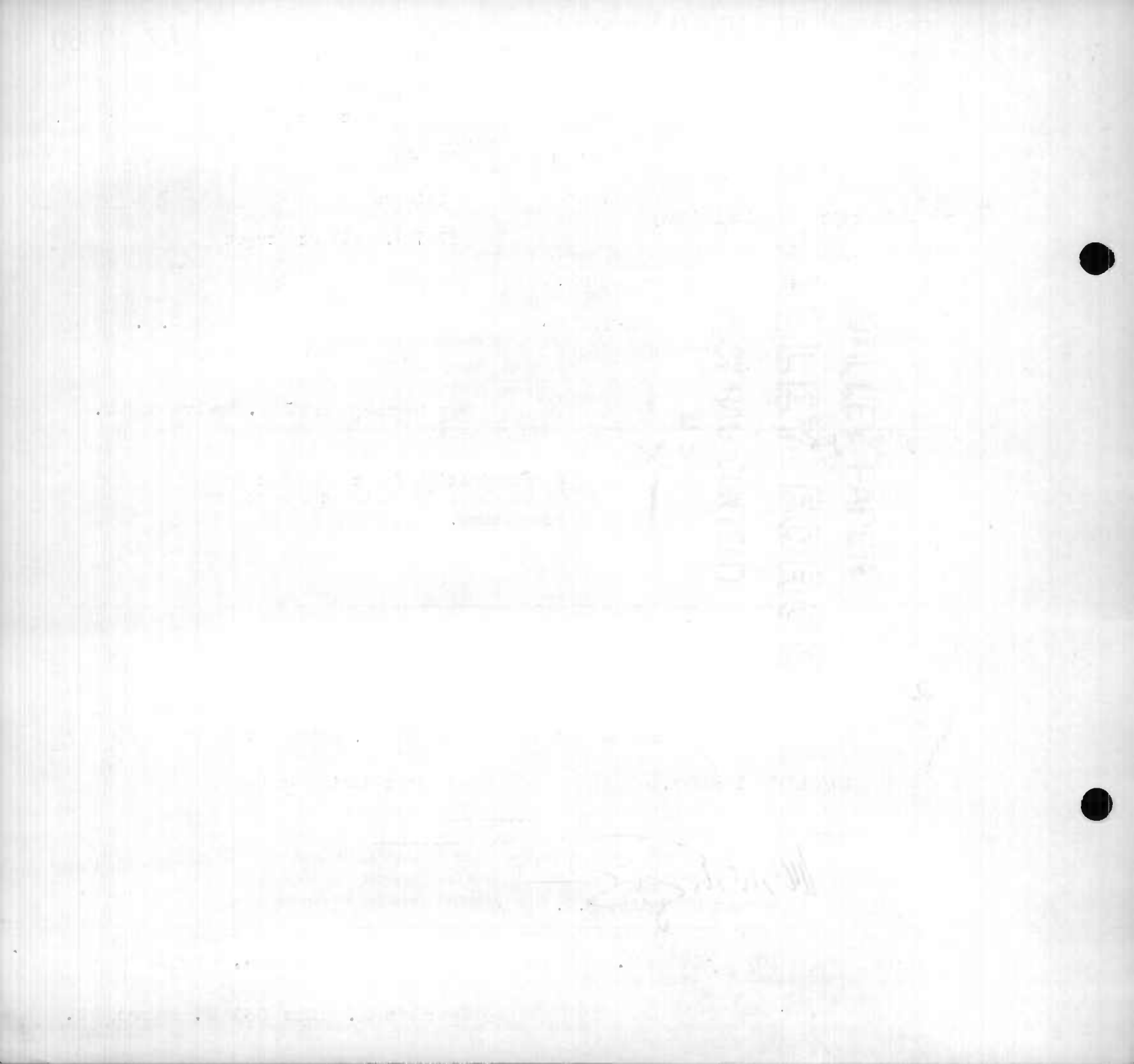
24B. NAME OF REGISTRAR

R. B. E. F. F.

24C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.



67 10061

BALTIMORE CITY HEALTH DEPARTMENT

67 10061

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CALVIN DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

October 20, 1967 2:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

812 South Sharp Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

9/10/45

9. AGE (In years
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ben Davis

14. MOTHER'S MAIDEN NAME

Hattie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Ben Davis 2718 Lanretta Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Fatty metamorphosis of liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S
NAME (Type)Charles S. Springate, M.D. ASSOCIATE MEDICAL EXAMINER ☐

October 20, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/24/67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Brooklyn, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 23 1967

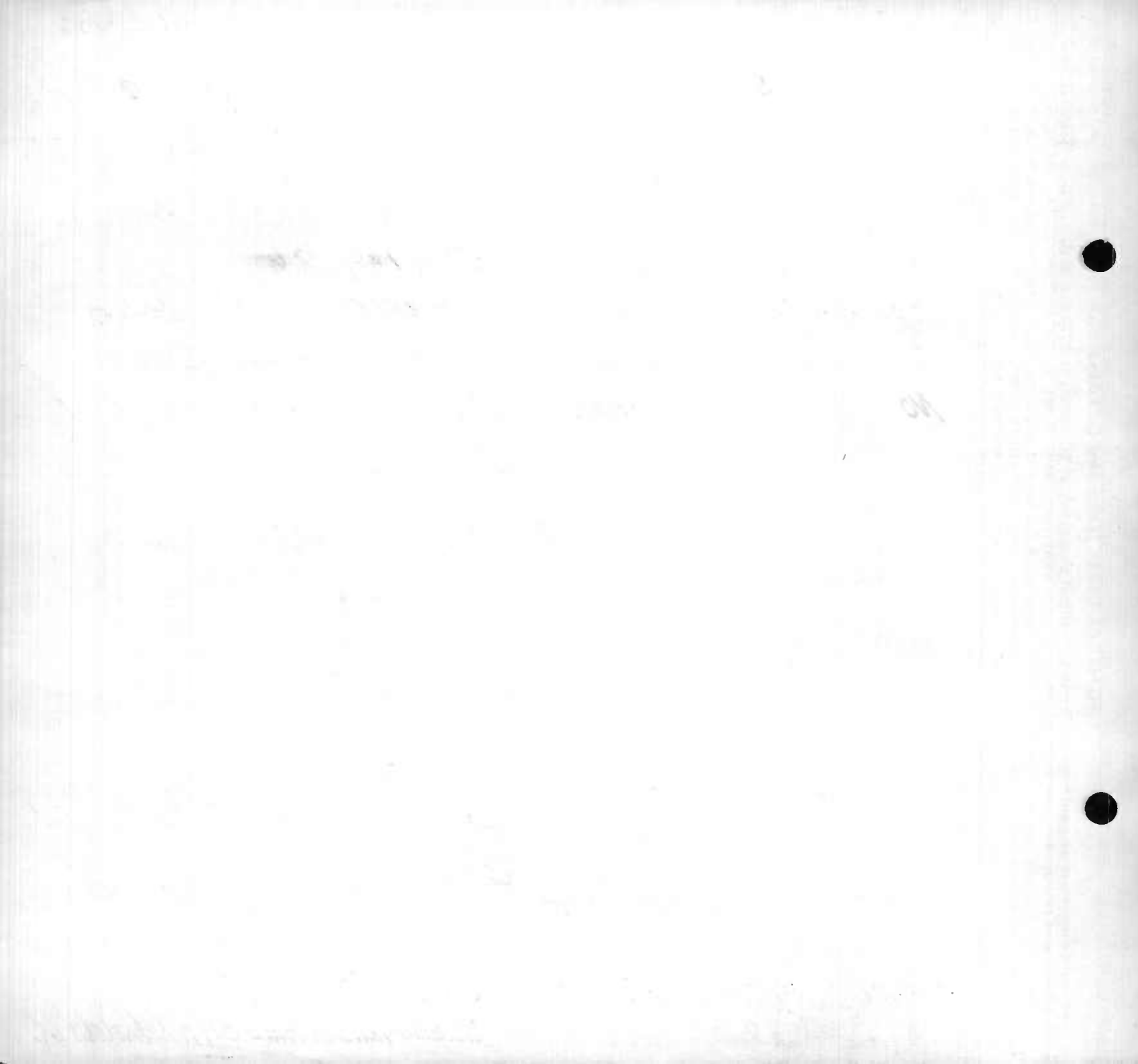
Charles A. Rice

Charles A. Rice 661 W. Barre St.

W/ALB. 11 PM
11/10/1914
11/10/1914

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10062	
BIRTH NO. 67 10062		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY E. BOYER		2. DATE AND HOUR OF DEATH 10/19/67 10:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND 38 Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 405 Oxford Ct BALT 1			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 5/19/1881	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) BALTO-MD.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Kennard			14. MOTHER'S MAIDEN NAME ELIZABETH SCOTT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Robert MASON 4645 Falls Road	
18. 332 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Thrombosis OF BRANCH OF Right middle cerebral Artery (B) Atherosclerotic cerebrovascular + ARTERIO VASCULAR Disease — (C) —			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10/18 1967 to 10/19 1967 , that (1) (we) last saw the deceased alive on 10/19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sandra Z. Salan M.D.				23B. DATE SIGNED 10/19/67	
23C. PHYSICIAN'S NAME (Type) Sandra Z. Salan M.D.		23D. ADDRESS University of Md. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/24/67		24C. NAME OF CEMETERY or CREMATORY Mt. Vernon Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967			
25B. NAME OF REGISTRAR Robert E. Fairman		25C. FUNERAL DIRECTOR ADDRESS Williams Funeral Home 319 N. Schroeder St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

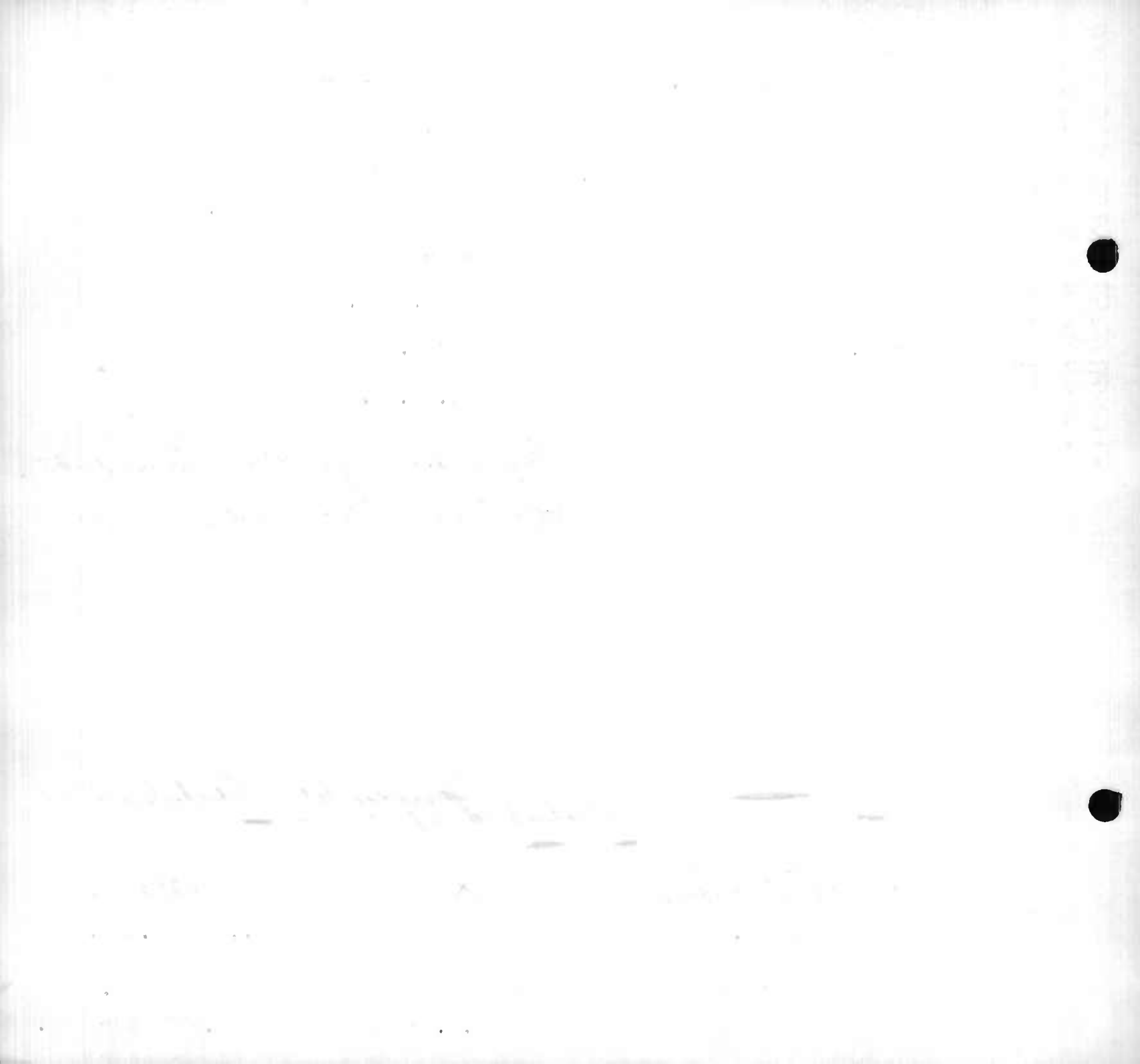
BIRTH NO. 67 10063		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10063	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BOZZIE MAYFIELD		10-18-67 9 28 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
The Johns Hopkins Hospital 33		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		1718 E. NORTH AVENUE	
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-19-40	9. AGE (In years lost birthday) 27	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NONE				S.C.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		WILLIE MAYFIELD		IDA MAE LANN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		250-70-2952		MALINDA MAYFIELD 1748 E. NORTH AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I ? Dehydration		(A) DUE TO		1 week	
ANTECEDENT CAUSES		(B) DUE TO		1 year	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Colonie Ca		3 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Nausea abd. distention & hypoventilation			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
11-15-66		Rectal Ca		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NONE					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-16 19 67 to 10-18 19 67, that (I) (we) last saw the deceased alive on 10-18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Timothy J. Gardner				23B. DATE SIGNED 10-18-67	
23C. PHYSICIAN'S NAME (Type) TIMOTHY J. GARDNER				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		10-22-67		ARBUTUS	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 23 1967		Robert E. Taylor, M.D.		JOSEPH KNIGHT 1639 N. BROADWAY	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> B-530 67 10064 BALTIMORE CITY HEALTH DEPARTMENT </div>		<div style="display: flex; justify-content: space-between;"> 67 10064 CERTIFICATE OF DEATH </div>		Registered No.	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		9 40 P M.	
Katherine N. Bennett		10-20-67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
100 103 Churchwardens Rd.		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 103 Churchwardens Rd.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1-19-1901	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Neville		14. MOTHER'S MAIDEN NAME Mary C. Winters			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. S. N. Whitaker	
				ADDRESS Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Myocardial Infarction Immediate (B) DUE TO Hypertensive Cardiovascular disease 6 yrs (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>January 1961</u> to <u>October 1967</u> . that (I) (we) lost soul the deceased alive on <u>September 19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Allan A. Spier		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 10/23/67	
23C. PHYSICIAN'S NAME (Type) Allan A. Spier		23D. ADDRESS M.D. 1501 Pentridge Rd., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-23-67		24C. NAME of CEMETERY or CREMATORY New Cathedral	
				24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

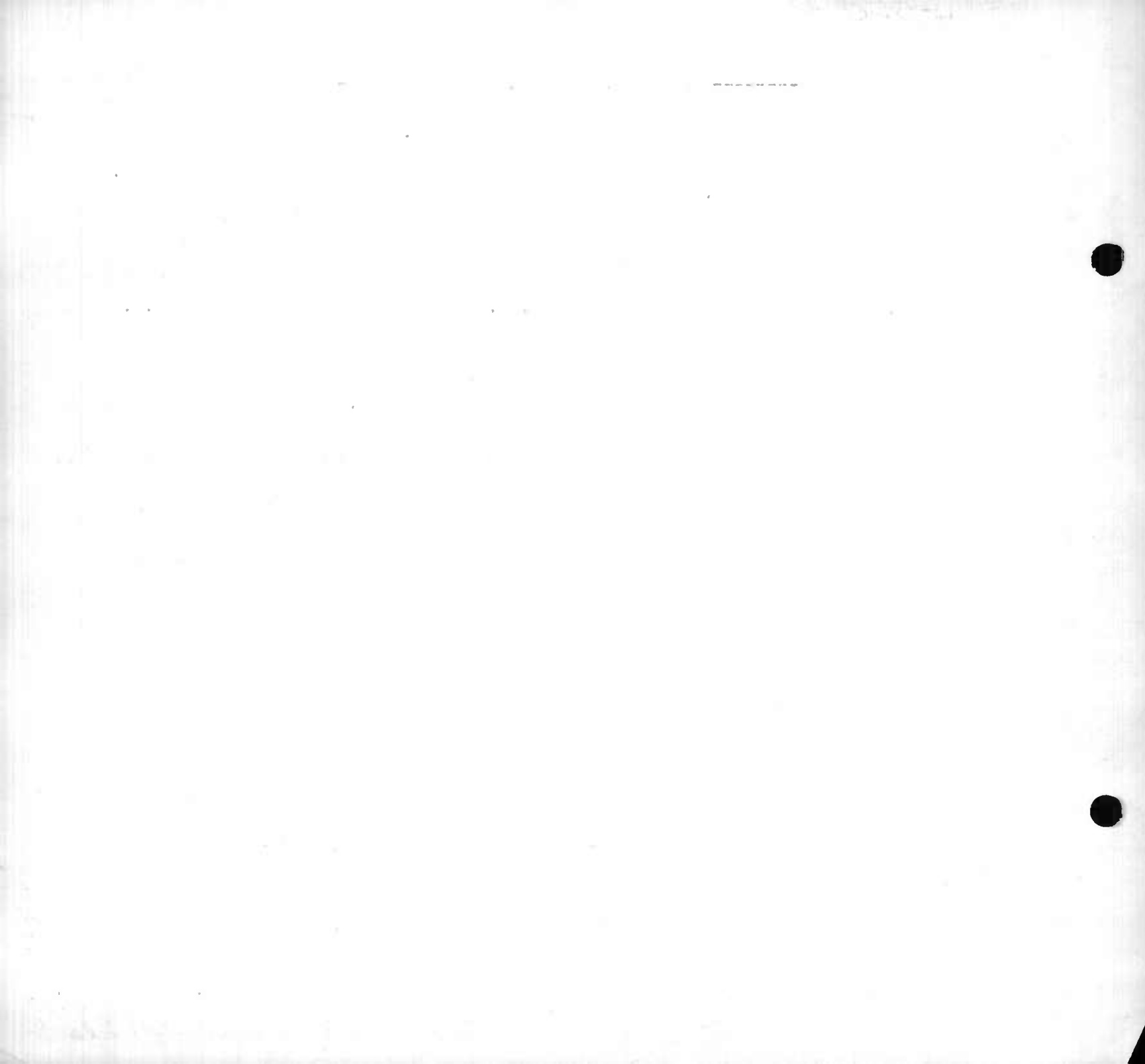
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
C-636		67 10065		67 10065	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		Genevieve A. Cordrey		2. DATE AND HOUR OF DEATH 10-20-67 4 ¹⁵ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospt.		A. STATE Maryland B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-12			
		D. STREET ADDRESS (If rural, give location) 5429 Springlake Way			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-22-1900	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Balto., Md.	
13. FATHER'S NAME Samuel I. Wright		14. MOTHER'S MAIDEN NAME Bridget Coughlin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-3286		17. INFORMANT Joseph M. Cordrey	
				ADDRESS Above	
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X1		CAUSE OF DEATH (A) Ruptured Aortic Aneurysm DUE TO (B) Hypertensive Arteriosclerotic CVD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Sudden 4 min. 10 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		none			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 19 60 to Oct 20 19 67, that (I) (we) last saw the deceased alive on Oct 16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.					
23A. SIGNATURE Joseph F. LiPira M.D.				23B. DATE SIGNED 10/21/67	
23C. PHYSICIAN'S NAME (Type) Joseph F. LiPira M.D.				23D. ADDRESS 8400 Loch Raven Blvd., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-24-67		24C. NAME of CEMETERY or CREMATORY New Cathedral	
				24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	
				ADDRESS 4905 York Rd.	

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 10066</u>	
BIRTH NO. <u>L-520</u>		67 10066		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Baltimore James A. Long Sr.</u>		2. DATE AND HOUR OF DEATH <u>10-20-1967</u> <u>7:10 pm</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u> Gould Conv.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>7423 Kenlea Avenue Baltimore, Md.</u> D. STREET ADDRESS (If rural, give location) <u>7423 Kenlea Avenue 21236</u> <u>53-00</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>5-22-1882</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Foreman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore & Ohio R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Long</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-06-3407</u>		17. INFORMANT ADDRESS <u>Mrs Bessie M. Long 7423 Kenlea Avenue 36</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>443X</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>CVA - left sided.</u> (B) DUE TO <u>Atherosclerotic Cardis</u> (C) <u>Vascular Disease with hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>approx 4 hrs.</u> <u>under</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>67</u> to <u>10-20</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-20</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>examined at 6 pm.</u>					
23A. SIGNATURE <u>John C. Hyle</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>10-21-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN C. Hyle</u>		23D. ADDRESS M.D. <u>7527 Belair Rd Baltimore Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-23-1967</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 23 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>Tassah Tunnel Home</u>		25D. ADDRESS <u>7411 Belair Rd</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-626		67 10067		Baltimore City Health Department		Registered No. 67 10067	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Hilda ALWILDA PARKER				10.19.67		12 ⁰⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
33				D. STREET ADDRESS (If rural, give location) 1810 E. LANVALE STREET			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
FEMALE	NEGRO	WIDOWED	4-29-88	79			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
DOMESTIC (R)			MD				
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
SYLVESTER MORTIMER				ELLEN JONES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Juanita Webb		1632 N. Durham ST	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				11 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Massive CVA DUE TO (B) Atherosclerotic cardiovascular ? DUE TO (C) disease			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetic ketoacidosis							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
10.10.67		R/O subdural		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 10-7 to 10-19 1967, that (I) (we) last saw the deceased alive on 10.19 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Christopher B. Merrett						10.19.67	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
Christopher B. Merrett						Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		10/23/67		MT. CALVARY		A. A. County, Md.	
25A. DATE		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
10/23/67		Robert E. Farkner		Joseph S. Lock		1304 N. Central Ave	

Trustees of

M. S.

Elizabeth Jones

Trustees of the West & East

of the
of the
of the

of the

of the

of the

of the

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FREDERICK (FREDDIE) BRANCH

2. DATE AND HOUR PRONOUNCED DEAD

October 20, 1967 8:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)

746 Pennsylvania Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1516 Pennsylvania Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Never married

8. DATE OF BIRTH

11-20-34

9. AGE (in years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABOUR

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Richmond VA.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

FREDDIE BRANCH

14. MOTHER'S MAIDEN NAME

Beaton Beatrice

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL
SECURITY NO.

579-48-0967

17. INFORMANT

Mrs Beatrice Beaton Wash. DC

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Fatty Alteration of Liver

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Partial

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/21/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10-25-67

23C. NAME of CEMETERY or CREMATORY

Harmony Landau m.d.

23D. LOCATION (City, town, or county)

Landau m.d.

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 23 1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Walter - Long Funeral Home

ADDRESS

3435-14 St. m.w. D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10069		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10069	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MR. JOHN BROOKS		2. DATE AND HOUR OF DEATH Oct 21, 1967 1:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived (If institution: residence before admission) A. STATE B. COUNTY Md.		5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-10	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & 35 Hospital		6. STREET ADDRESS (If rural, give location) 32 S. East Ave		7. MARIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
15. SEX M	16. RACE W	8. DATE OF BIRTH 2/17/90	9. AGE (In years last birthday) 77	10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist (retired)		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, ne or unknown) (If yes, give war or dates of service) no -----	
16. SOCIAL SECURITY NO. 213-09-2738		17. INFORMANT Lillian B. Brooks		ADDRESS 32 S. East Avenue	
18. 203X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Multiple Myeloma DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 21, 1967 to Oct 21, 1967, that (I) (we) last saw the deceased alive on Oct 21, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis Baltazar				23B. DATE SIGNED Oct 21, 1967	
23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAZAR		23D. ADDRESS Church Home & Hosp Baltimore 31, Md.		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/25/67		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. OCT 23 1967		24F. NAME OF REGISTRAR Robert E. Fisher	
24G. FUNERAL DIRECTOR John A. Moran, Inc.		24H. ADDRESS 3000 E. Baltimore St.		24I. DATE OF DEATH OCT 21 1967	

67 10070

BALTIMORE CITY HEALTH DEPARTMENT

67 10070

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MALCOMB

Joseph

MEYERS

2. DATE AND HOUR PRONOUNCED DEAD

October 22, 1967

8:07 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4812 Reisterstown Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single c

8. DATE OF BIRTH

3/12/1916

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintainance Worker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Daniel Meyers

14. MOTHER'S MAIDEN NAME

Clarise R. Diehl

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

M M Yes

Korean

16. SOCIAL
SECURITY NO.

264341387

17. INFORMANT

Mrs. Marguerite Benarick-

ADDRESS

1004 Rosemont

Joppatowne Md

18.

921.9-322.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia due to obstruction of air-
~~XXXX~~ way by foreign body (food)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Acute alcoholic Intoxication

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

00-00

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREM.D. ASSISTANT MEDICAL EXAMINER ☒EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

10/22/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/25/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem Baltimore Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 23 1967

24B. NAME OF REGISTRAR

Robert E. Fickens

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. 5305 Harford Rd.

WILLIAMS' FOLDING

WILLIAMS' FOLDING

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10071				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 10071	
1. NAME OF DECEASED (Type or Print) <u>Mary D Doyle</u>				2. DATE AND HOUR OF DEATH <u>10/22/67</u> <u>3 A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2708 Inglewood Ave</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2708 Inglewood Ave</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9/22/1901</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph B Meyer</u>			14. MOTHER'S MAIDEN NAME <u>Carrie Street</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>James J Doyle Jr. 207 Margate Rd.</u>		
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO <u>Coronary thrombosis</u> (B) DUE TO <u>Arteriosclerosis</u> (C) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u> <u>10 years</u> <u>10 years +</u> <u>10 years +</u>		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>May 1966</u> to <u>10/22 1967</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Sept 6 1967</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <u>Alan Bernstein</u> M.D.				23B. DATE SIGNED <u>10/23/67</u>			
23C. PHYSICIAN'S NAME (Type) <u>Alan Bernstein</u>				23D. ADDRESS M.D. <u>819 Park Ave Baltimore 2, 201</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/25/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 23 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Feltner</u>		25C. FUNERAL DIRECTOR <u>Leonard J Ruck Jr. 5305 Harford Rd.</u>			

Admission
Hypertension
Atherosclerosis
Coronary thrombosis

814 Park Ave. Room 2
10/2/54
L. E. Bunker
10/2/54
10/2/54

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 10072</u>
BIRTH NO. <u>67 10072</u>		CERTIFICATE OF DEATH		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MR. BERNARD R. SMITH Sr.</u>		
2. DATE AND HOUR OF DEATH <u>5:45 AM Oct 20, 1967</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Harris Co.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL HOSPITAL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>JOPPA 21085 162-00</u>		
		D. STREET ADDRESS (If rural, give location) <u>419 HASLETT RD.</u>		
5. SEX <u>M.</u>	6. RACE <u>CAUC.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED.</u>	8. DATE OF BIRTH <u>28 MAY 1900</u>	9. AGE (In years last birthday) <u>67</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STOCKKEEPER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BALTO. CITY DEPT OF EDUCATION</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>				
13. FATHER'S NAME <u>EDWARD B SMITH.</u>		14. MOTHER'S MAIDEN NAME <u>ELLA J. ROBINETTE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>220-14-6067</u>		17. INFORMANT <u>Mrs. Ethel M. Smith WIFE</u>
ADDRESS <u>same</u>				
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOPNEUMONIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>BRONCHOGENIC CARCINOMA</u> <u>W. K. W.</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>PULMONARY EMPHYSEMA</u>		INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>19 Oct.</u> <u>19 67</u> to <u>20 Oct.</u> <u>19 67</u> , that (I) (we) lost saw the deceased alive on <u>5:45 AM 20 Oct.</u> <u>19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>D H Brancato</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>20 Oct 1967</u>
23C. PHYSICIAN'S NAME (Type) <u>D.H. BRANCATO</u>		23D. ADDRESS M.D. <u>UNION MEMORIAL HOSPITAL.</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10/23/67</u>	24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 23 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc</u> <u>LEONARD RUCK</u>
				ADDRESS <u>Balto. Md.</u>

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MARKYARD

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ELLA J ROBINETTE

EDWARD B SMITH

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10073	
BIRTH NO. 67 10073		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY M. MARSIGLIA		2. DATE AND HOUR OF DEATH 10/22/67 10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-38			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 1347 SHERWOOD AVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-25-98	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES B. McCUNNY		14. MOTHER'S MAIDEN NAME MARY L. RALEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ANTHONY B. MARSIGLIA ADDRESS JAME AS Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Pneumonia		CAUSE OF DEATH (A) DUE TO Unresolved Atherosclerosis (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 10/22/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Aio Sputum Aspiration		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 10/13 19 67 to 10/22 19 67 , that (I) last saw the deceased alive on 10/22 19 67 and that in (my) (our) apinian death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
23A. SIGNATURE W. H. Oehlert Jr.				23B. DATE SIGNED 10/22/67	
23C. PHYSICIAN'S NAME (Type) WILLIAM H. OEHLERT JR M.D.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/26/67		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		25D. ADDRESS 5305 Harford Rd.	

Union Memorial Hosp
F W married

Charles B McGinnis

1347 Sherwood Ave
15-2-28 08
Baltimore
Maryland

May 1 1904
Arthur B McGinnis
Maryland

Charles McGinnis
Baltimore

10/25/07 no 2nd registration

10/25
10/12
10/5
10/23/07

W. H. Coffey

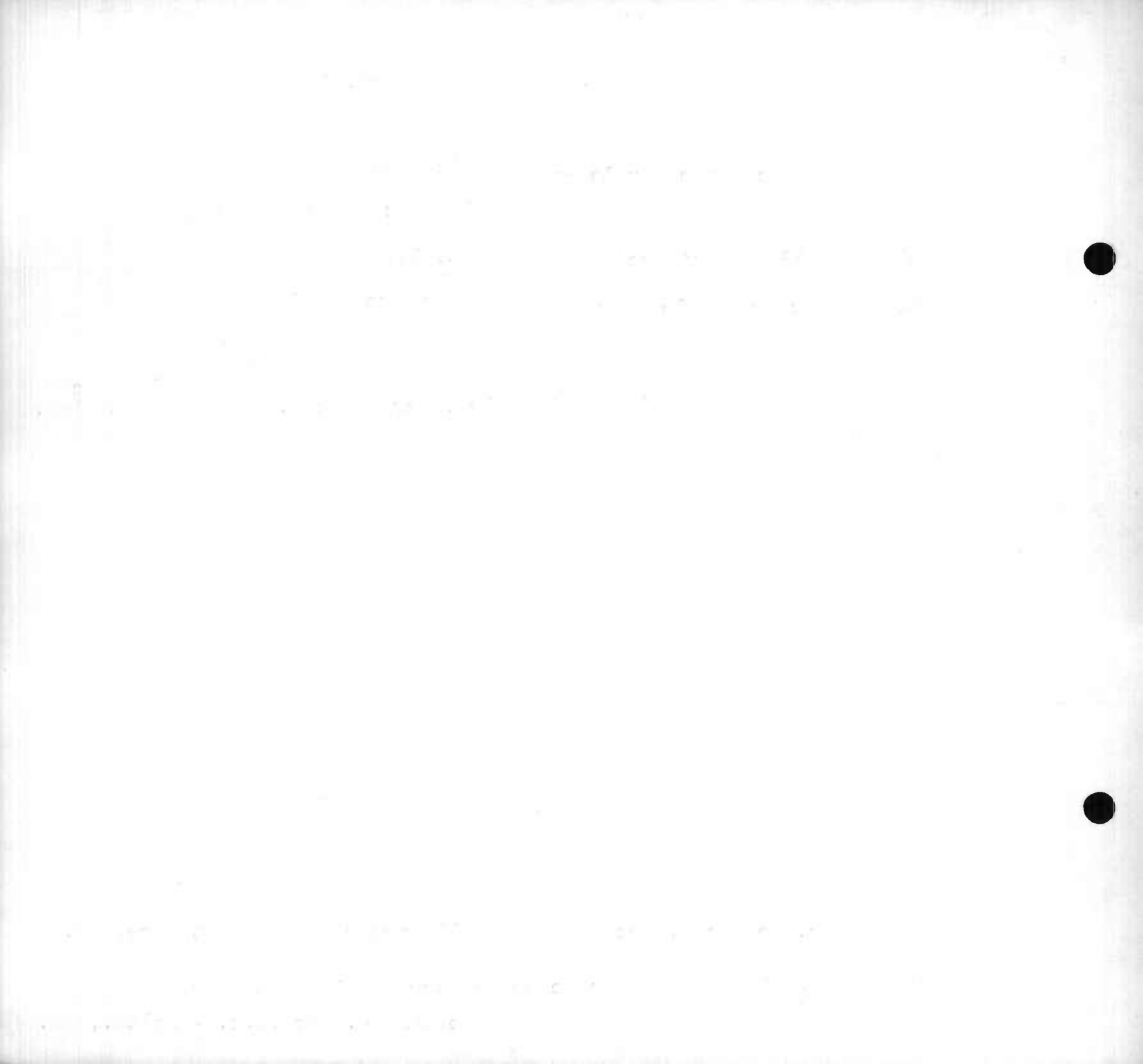
ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/12/07 BY 60322 UCBAW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

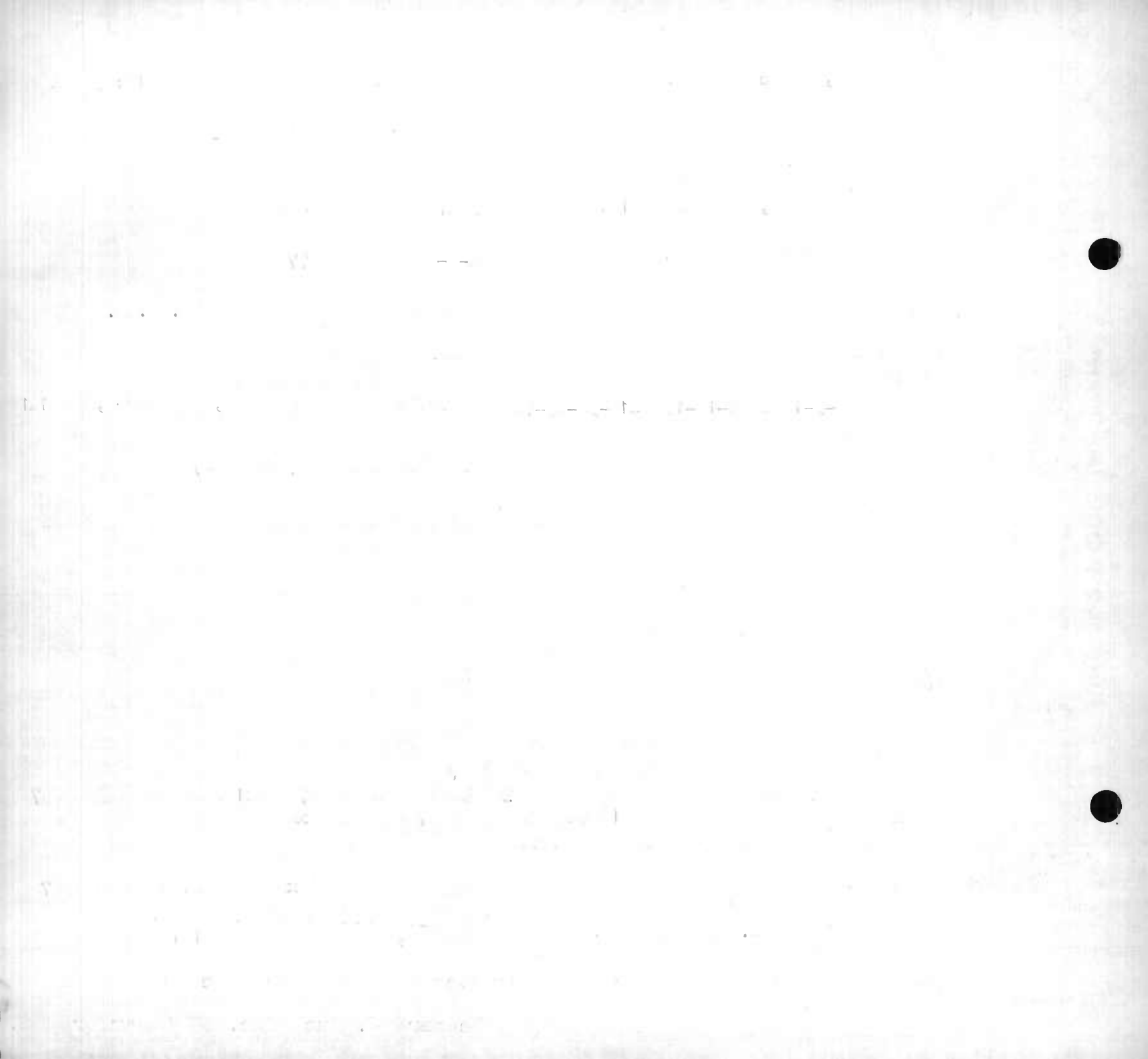
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10074	
BIRTH NO. 67 10074		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FREDERICK J. SEHMAN		Oct. 22, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
00 6140 Loch Raven Boulevard		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		6140 Loch Raven Boulevard			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
male	white	widowed	Jan. 19, 1898	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ret. Dispatcher		Elevator		Baltimore Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Harmon Sehman			Costillia Miles		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		215 10 1680		Mrs. Geraldine H. Lowman-Raven Blvd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) ASCVD			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 19 61 to 10/22/67, that (I) (we) last saw the deceased alive on 10/2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
George H. Beck				10/23/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. George H. Beck		6012 Harford Road, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10/25/67		Holy Redeemer Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
10/23/67		Robert E. Talley		Leonard J. Ruck, Inc. - Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10075		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 10075	
1. NAME OF DECEASED (Type or Print) DORL, Raymond ; J.			2. DATE AND HOUR OF DEATH 21 OCTOBER 1967 12:05 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5927 LILLYAN AVENUE		
5. SEX MALE	6. RACE CAUCASION	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-7-90	9. AGE (In years last birthday) 77	10. Under 1 Yr. Months: Days: Hours: Min. 11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNK		10B. KIND OF BUSINESS OR INDUSTRY UNEMPLOYED		11. BIRTHPLACE (State or foreign country) AUSTRIA	
13. FATHER'S NAME JOHN DORL			14. MOTHER'S MAIDEN NAME PAULINE RAYMON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 5-3-18 TO 2-18-19		16. SOCIAL SECURITY NO. 218-54-25-78		17. INFORMANT HOSPITAL RECORDS ADDRESS VAH, 3900 LOCH RAVEN BLVD, BALTIMORE, MD 21218	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION (PROBABLE) DUE TO II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HIST OF MYOCARDIAL INFARCTION DUE TO SEVERAL YEARS			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 28 SEPTEMBER 19 67 to 21 OCTOBER 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 21 OCTOBER 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE John L. Cameron M.D.				23B. DATE SIGNED 21 OCTOBER 1967	
23C. PHYSICIAN'S NAME (Type) JOHN L. CAMERON			23D. ADDRESS 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/1/24/67	24C. NAME of CEMETERY or CREMATORY Pine Grove Cemetery		24D. LOCATION (City, town, or county) (State) Sunnyburn, Pennsylvania	
25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10076	
CERTIFICATE OF DEATH					
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Mr. Gabriella Valle</i>		
2. DATE AND HOUR OF DEATH <i>10-21-67 2:50 P. M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>			A. STATE <i>Md</i> B. COUNTY <i>Balto. Co</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Phoenix 53-00</i>		
D. STREET ADDRESS (If rural, give location) <i>48 40 Club View La.</i>					
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>1-5-1881</i>	9. AGE (In years last birthday) <i>86</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Mason</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Stone</i>	11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Louis Valle</i>			14. MOTHER'S MAIDEN NAME <i>Theresa Altomare</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>218032041</i>		17. INFORMANT ADDRESS <i>Mr. Charles J. Valle 40 Club View Rd.</i>
18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Infarction</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerotic peripheral vascular disease & occlusion</i> <i>+ secondary gangrene</i>			CAUSE OF DEATH (A) <i>Acute Myocardial Infarction</i> DUE TO <i>Arteriosclerotic peripheral vascular disease & occlusion</i> (B) <i>Arteriosclerotic peripheral vascular disease & occlusion</i> DUE TO <i>+ secondary gangrene</i> (C) <i>+ secondary gangrene</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Chronic Emphysema possible intestinal obstruction</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7 day</i>		
19A. DATE OF OPERATION <i>10-20-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <i>10-13-</i> 19 <i>67</i> to <i>10-21-</i> 19 <i>67</i> , that (I) (<u>we</u>) last saw the deceased alive on <i>10-21-</i> 19 <i>67</i> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.					
23A. SIGNATURE <i>Fred J. Bjornsson</i>			23B. DATE SIGNED <i>10-21-67</i>		
23C. PHYSICIAN'S NAME (Type) <i>Dr. Elijah Saunders</i>			23D. ADDRESS <i>Maryland General Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/25/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 23 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairburn</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>	
25D. ADDRESS <i>5305 Harford Rd., Balto. Md. 21214</i>					

14

1941

40 Club View Rd.

1-2-1941

220

Italy

1941

Louis Valley

1941

Italy

Notes for 1941
1941-1942
1942-1943
1943-1944

+ 2 secondary programs

1941-1942

possible industrial education

10-15

10-15

10-15

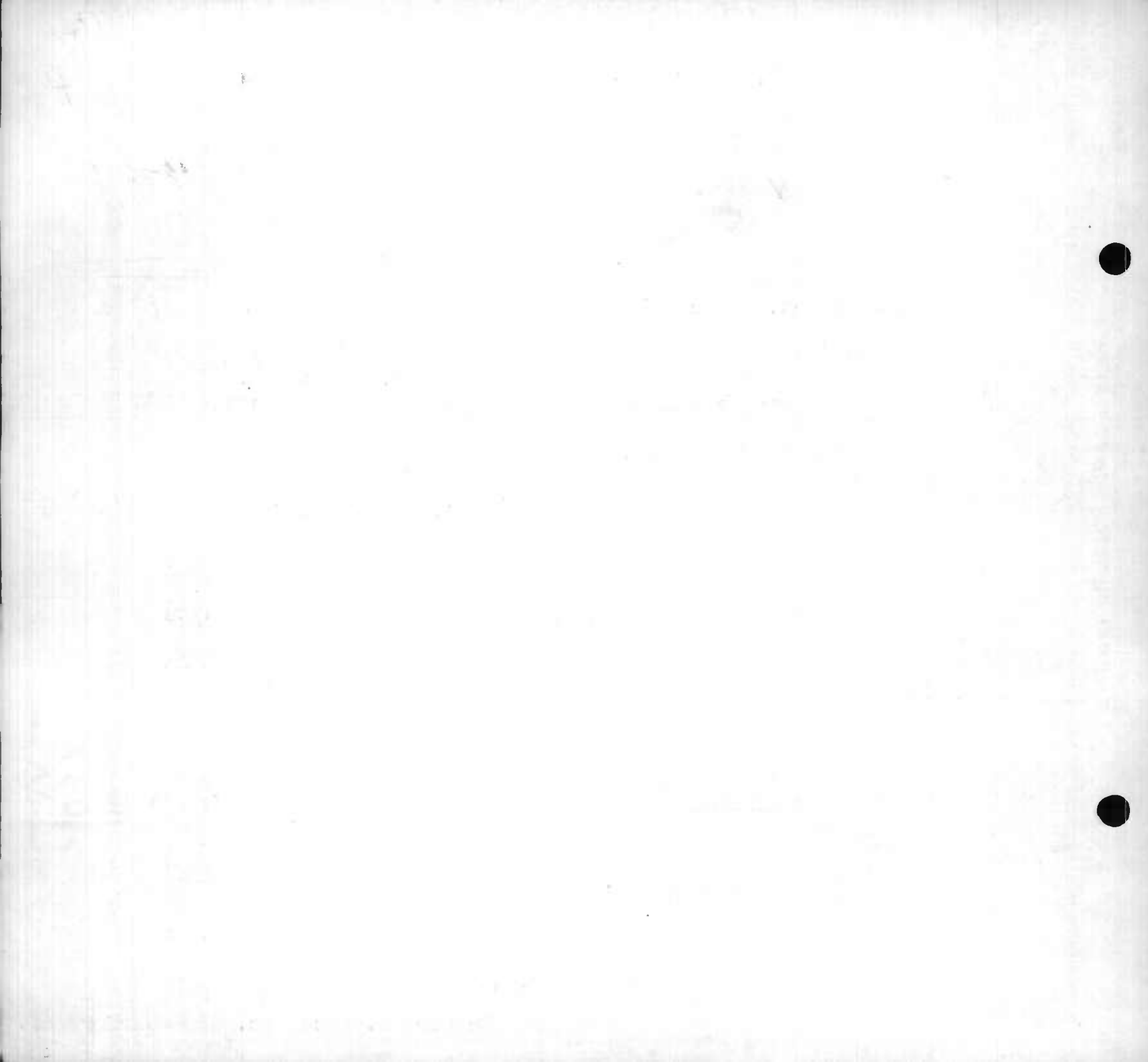
10-15

10-15

1941-1942

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10077	
67 10077				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Carrie L. Shettle</i>				<i>10-22-67 12:15 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>Baltimore</i>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		<i>14-01</i>	
		D. STREET ADDRESS (If rural, give location) <i>Bolton Hill Nursing Home</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>3/30/88</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months/ Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>XXXXXX Ret.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>School Board</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Conrad Poehlman</i>		14. MOTHER'S MAIDEN NAME <i>Lena Schueller</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213501709</i>		17. INFORMANT <i>Mr. Clinton E. Shettle</i>	
				ADDRESS <i>7204 Barlow Ct</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>420.1 I</i>		CAUSE OF DEATH <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <i>Arteriosclerotic Heart Disease</i>			
		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Hypertensive Heart Disease</i>			
19A. DATE OF OPERATION <i>10-22-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-35</i> 19 <i>67</i> to <i>10-22</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>10-22</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William L. Bodie</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10/22/67</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>Maryland General Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/26/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Oaklawn Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 23 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>	
				ADDRESS <i>5305 Harford Rd.</i>	



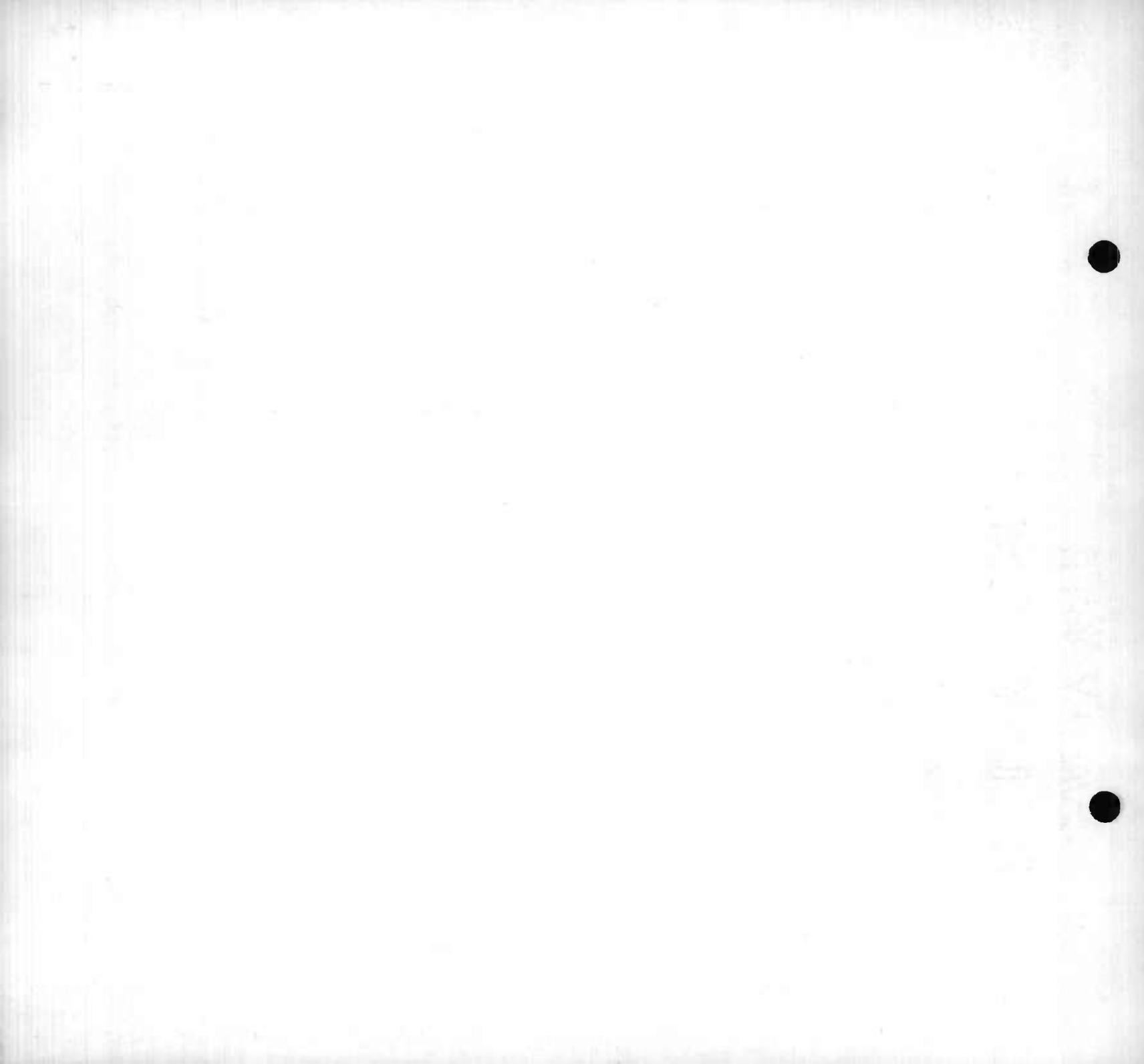
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 10078		BALTIMORE CITY HEALTH DEPARTMENT		67 10078	
BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GARY, CARRIE		2. DATE AND HOUR OF DEATH 10-22-67 10:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION BOLTON HILL NURSING CENTER <small>(If not in hospital or institution, give street address or location)</small>		C. CITY OR TOWN (If outside city limits, give RURAL and give township) BALTIMORE			
90		D. STREET ADDRESS (If rural, give location) 3600 PAINE ST			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOW (specify)	8. DATE OF BIRTH 2-8-62	9. AGE (In years last birthday) 5	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME BRICE, JOSEPH		14. MOTHER'S MAIDEN NAME CONLEY		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214 14 2852		17. INFORMANT ADMISSON RECORD (CHART)	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		(A) Coronary Vascular atherosclerosis DUE TO		INTERVAL BETWEEN ONSET AND DEATH 15 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) non functioning right kidney DUE TO		years	
		(C) arteriosclerosis generalized DUE TO		years	
		(D) Hypertensive C.V. disease DUE TO		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/10 19 66 to 10/22 19 67 , that (I) (we) last saw the deceased alive on 10/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALLAN H. MACHT M.D.				23B. DATE SIGNED 10/23/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ALLAN H. MACHT M.D.		2 E. READ ST BALTD 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/25/67		24C. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery	
24D. LOCATION (City, town, or county) (State) Winfield, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 23 1967		ALLAN H. MACHT		Wm. Cook-Brooks Inc. Balto. Md. 21202	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10079	
67 10079				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Anna McCauley</i>				<i>10/22/67 6:45 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital</i>		A. STATE <i>MD</i> B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, with RURAL and give township) <i>Balto.</i>			
		D. STREET ADDRESS (If rural, give location) <i>5219 St. Charles Ave</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>9-13-95</i>	9. AGE (In years last birthday) <i>72</i>	(If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Edward Monroe Smith</i>			14. MOTHER'S MAIDEN NAME <i>Mary Jane Reynolds</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>?</i>	17. INFORMANT <i>MR. CHARENCE W. HUSS</i>		ADDRESS <i>21521 1569 William Ave.</i>
18. <i>4-22-1 I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>PULMON EDEMA</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>ASCVD & CHF</i>			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>10/17</i> 19 <i>67</i> to <i>10/22</i> 19 <i>67</i> , that (we) last saw the deceased alive on <i>10/21</i> 19 <i>67</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.					
23A. SIGNATURE <i>Edward R. Cohen, M.D.</i> M.D.				23B. DATE SIGNED <i>10/22/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>EDWARD R. COHEN</i> M.D.				23D. ADDRESS <i>SINAI HOSP.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10-26-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Woodlawn Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 23 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm Cook-Brooks Towson Inc.</i>	
				ADDRESS <i>1050 York Rd Towson, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 10080	
BIRTH NO. 67 10080		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Frank Leslie Mills</i>		2. DATE AND HOUR OF DEATH <i>10/21/67 7:50 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore City</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hosp.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 28-41</i>			
44		D. STREET ADDRESS (If rural, give location) <i>3714 Hillsdale Road</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED NEVER MARRIED MARRIED DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>02/11/91</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self Employed Auctioneer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Auctioneer</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Frank Mills</i>		14. MOTHER'S MAIDEN NAME <i>Katie Rouse</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-14-8995</i>		17. INFORMANT <i>Wife</i>	
18. <i>331X I</i>		CAUSE OF DEATH		ADDRESS <i>Same</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Cerebral hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) <i>Gen</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>10/21</i> 19 <i>67</i> to <i>10/21</i> 19 <i>67</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>10/21</i> 19 <i>67</i> and that in my <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> view the body after death.					
23A. SIGNATURE <i>B. J. Weckesser</i>				23B. DATE SIGNED <i>10/21/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>BARRY J. WECKESSER</i>				23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL Union Memorial Hosp</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10-25-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park</i>	
24D. LOCATION <i>Woodlawn</i>		24E. (City, town, or county) <i>Maryland</i>		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Wm. Cook-Brooks</i>		25C. FUNERAL DIRECTOR <i>Towson Inc. Towson, Md.</i>	

From the file

Union Memorial Hosp

M
W
Self employed
Frank Mills

W. W. W. W. W.
W. W. W. W. W.
W. W. W. W. W.

10/25/21
10/25/21
10/25/21

3714 Hillsdale Road

02/11/21

Harvard

Katie Rose

Wife

Central Memorial

10/25/21
10/25/21
10/25/21

Union Memorial

116 12 14
TYSON, EARL V.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-250 BIRTH NO.		67 10081 M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 10081	
1. NAME OF DECEASED (Type or Print) EARL V. TYSON (Verges)				2. DATE AND HOUR OF DEATH 10-21-67 5:00 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, give RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2635 GARRETT AVE.			
5. SEX MALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-1-1917	9. AGE (In years lost birthday) 50	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10B. KIND OF BUSINESS OR INDUSTRY Cab Co.		11. BIRTHPLACE (State or foreign country) Morgan N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WATT TYSON				14. MOTHER'S MAIDEN NAME FRANCES TILMON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-36-9154A		17. INFORMANT Benette Tyson		ADDRESS 2635 GARRETT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 177X I CARDIORESPIRATORY COLLAPSE 3 HRS CARCINOMA PROSTATE 24 HRS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 19 to 21 OCT 1967, that (X) (we) lost saw the deceased alive on 21 October 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.		23A. SIGNATURE Joseph C. White		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 21 OCT 67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
JOSEPH C. WHITE		THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 10-25-67	24C. NAME OF CEMETERY or CREMATORY CARVER Mem.	24D. LOCATION Laurel Md.				
25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967		25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR MORTON + DYE		ADDRESS 1701 LAURENS	

NO

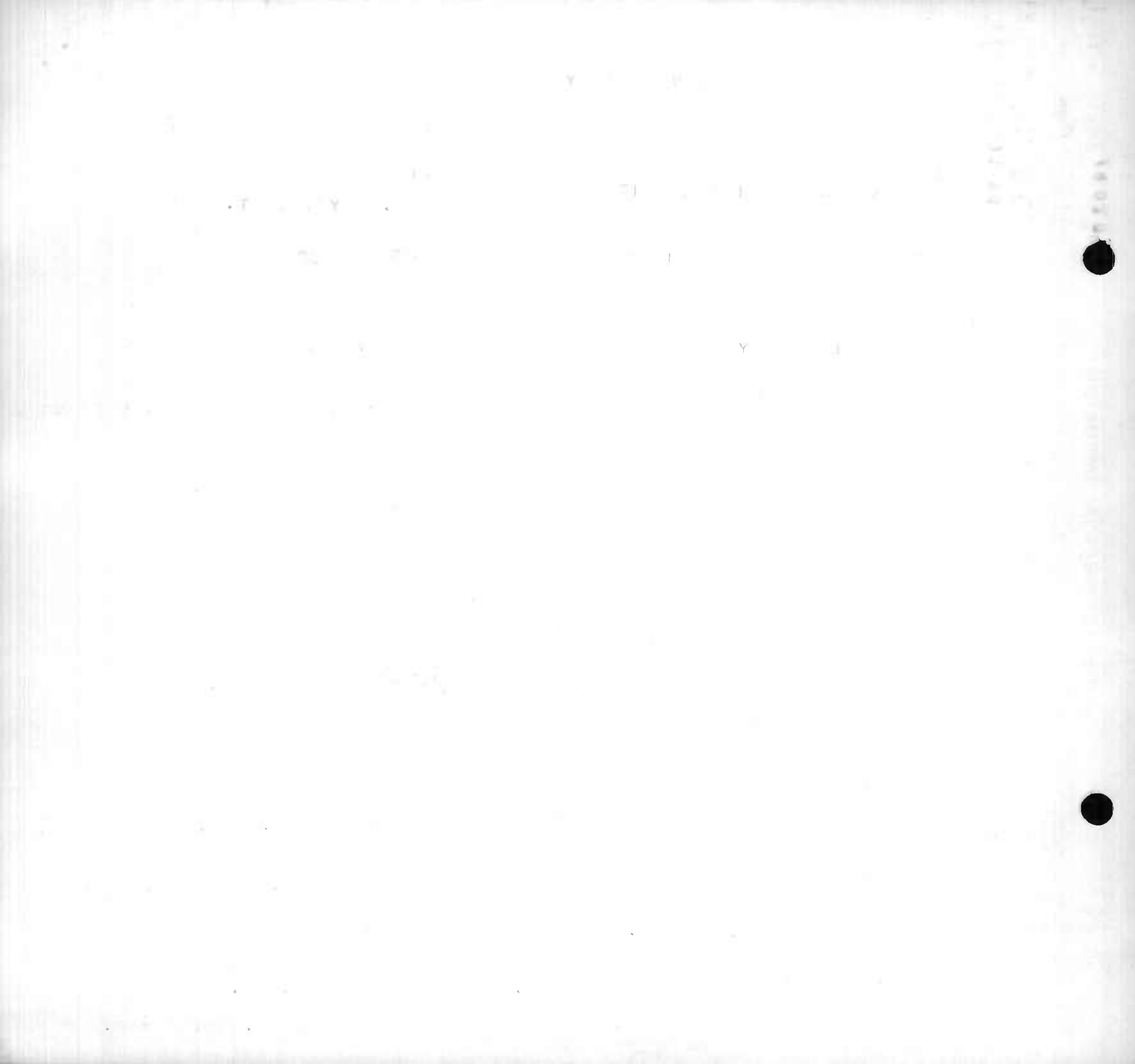
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 10082		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 10082	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Neatom Paylor		2. DATE AND HOUR OF DEATH 10/19/67 8:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital 33		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2233 Orleans St.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-8-94	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME John Paylor		14. MOTHER'S MAIDEN NAME Lucinda Paylor		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT David Paylor 1622 N. Caroline Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Renal Failure DUE TO (B) Hypotension DUE TO (C) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 4 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 10/14/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Sm. Bowel Intest. Obstruction		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/14/67 to 10/19/67, that (I) (we) last saw the deceased alive on 10/19/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard N. Scott		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 10/19/67	
23C. PHYSICIAN'S NAME (Type) RICHARD N. SCOTT		23D. ADDRESS JOHNS HOPKINS HOSP. (BALT, MD.)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/24/67		24C. NAME of CEMETERY or CREMATORY Roxboro, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. OCT 23 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Wm C March 928 E. North Ave.	

9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 8

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death, written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------|--|------------------|--|-------------------------------|--|--------------------------------|
| B-400 | | 67 10083 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10083 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 10/20/67 11:30 A.M. | | | |
| GENEVA BAILEY | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | A. STATE
B. COUNTY | | | |
| THE JOHNS HOPKINS HOSPITAL | | | | MARYLAND | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 1927 E. FAYETTE ST. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
lost birthday) | If Under 1 Yr.
Months Days | | If Under 24 Hrs.
Hours Min. |
| FEMALE | NEGRO | WIDOW | 6-14-07 | 60 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | Florida | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| SAMUEL RAMSEY | | | | CAREY ROCKER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | 213-34-3239 | | Edna Jones Morgan | | 2043 E. Hoffman St | |
| 1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | Cardiac Arrest | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| | | | | ? Pul. Embolus | | | |
| | | | | (C) DUE TO | | | |
| | | | | ? Ca of Pancreas | | | |
| II | | | | Cirrrosis | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/10/67 19 67 to 10/20 19 67, that (I) (we) last saw the deceased alive on 10/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Henry R. Black | | | | | | 10/20/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| HENRY R. BLACK | | | | Johns Hopkins Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 10/25/67 | | Arbutus Mem. Park | | Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| OCT 23 1967 | | J. B. E. FARRAR | | Wm C March | | 928 E. North Ave. | |



1
G-650

67 10084 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10084

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VANDALIAH

GREEN

2. DATE AND HOUR PRONOUNCED DEAD

October 22, 1967

9:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2200 Cecil Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, state RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2200 Cecil Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

M

8. DATE OF BIRTH

6/10/24

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Lee Shaw

14. MOTHER'S MAIDEN NAME

Bessie Shaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

James Green 2200 Cecil Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Rheumatic Heart Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/22/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/26/67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

(State)

Anne Arundel Cty., Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 23 1967

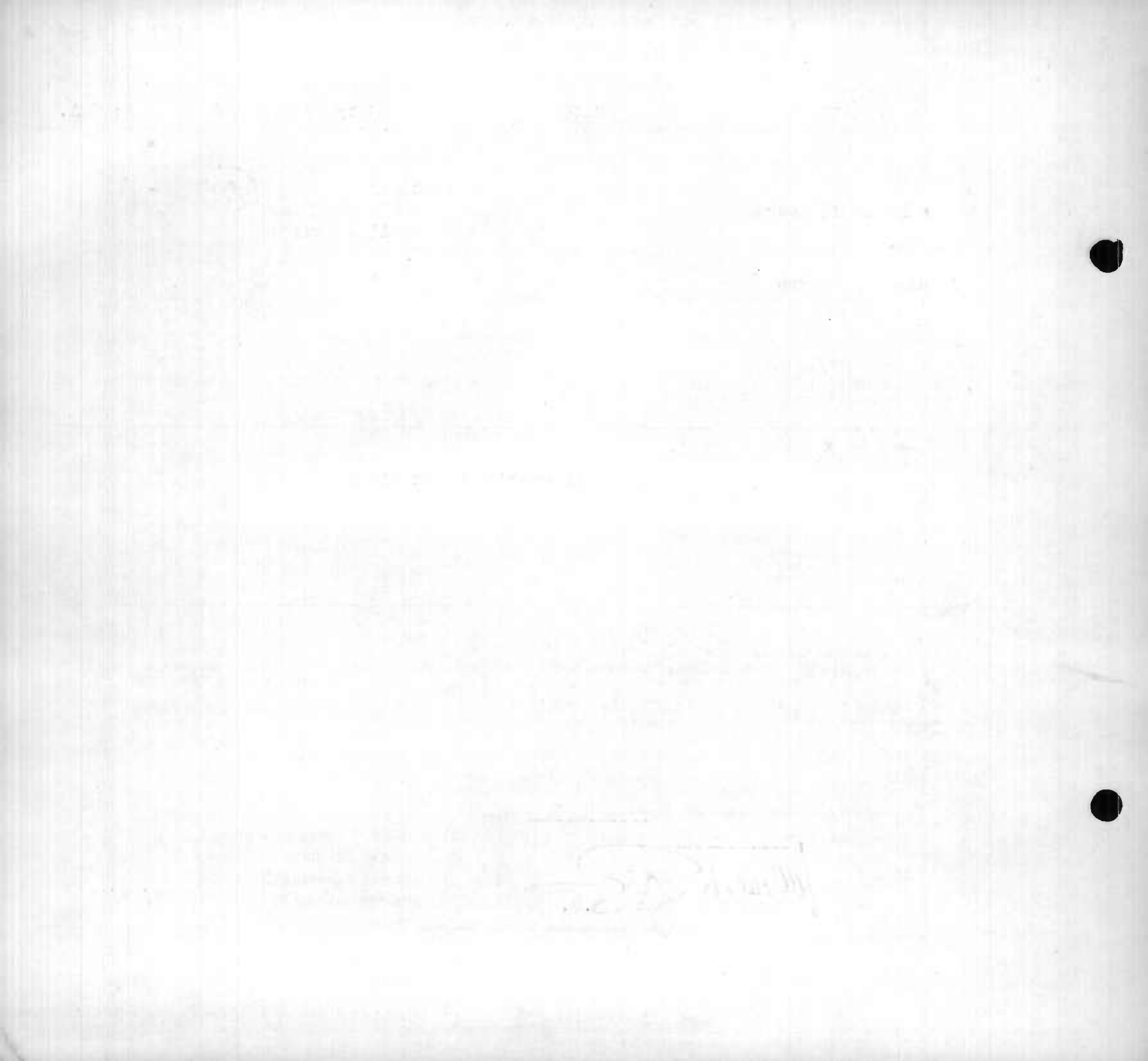
24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Wm C. MARCH 928 E. North Ave

ADDRESS



1
S-164

67 10085 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10085

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

OZELL

SPRUILL

2. DATE AND HOUR PRONOUNCED DEAD

October 21, 1967

10:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, with RURAL, give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3811 Bateman Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

12-11-1908

9. AGE (in years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

BETH-STEEL

11. BIRTHPLACE (State or foreign country)

MACON, NORTH CAROLINA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIE SPRUILL

14. MOTHER'S MAIDEN NAME

CORA SPRUILL

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Dora Spruill 3811 Bateman Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic and Hypertensive
XXXXX Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/22/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10-26-67

23C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park

23D. LOCATION (City, town, or county)

Arbutus,

Maryland

24A. DATE REC'D BY HEALTH DEPT.

OCT 23 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

MORTON & DYETT F.H. 1701 Laurens St.

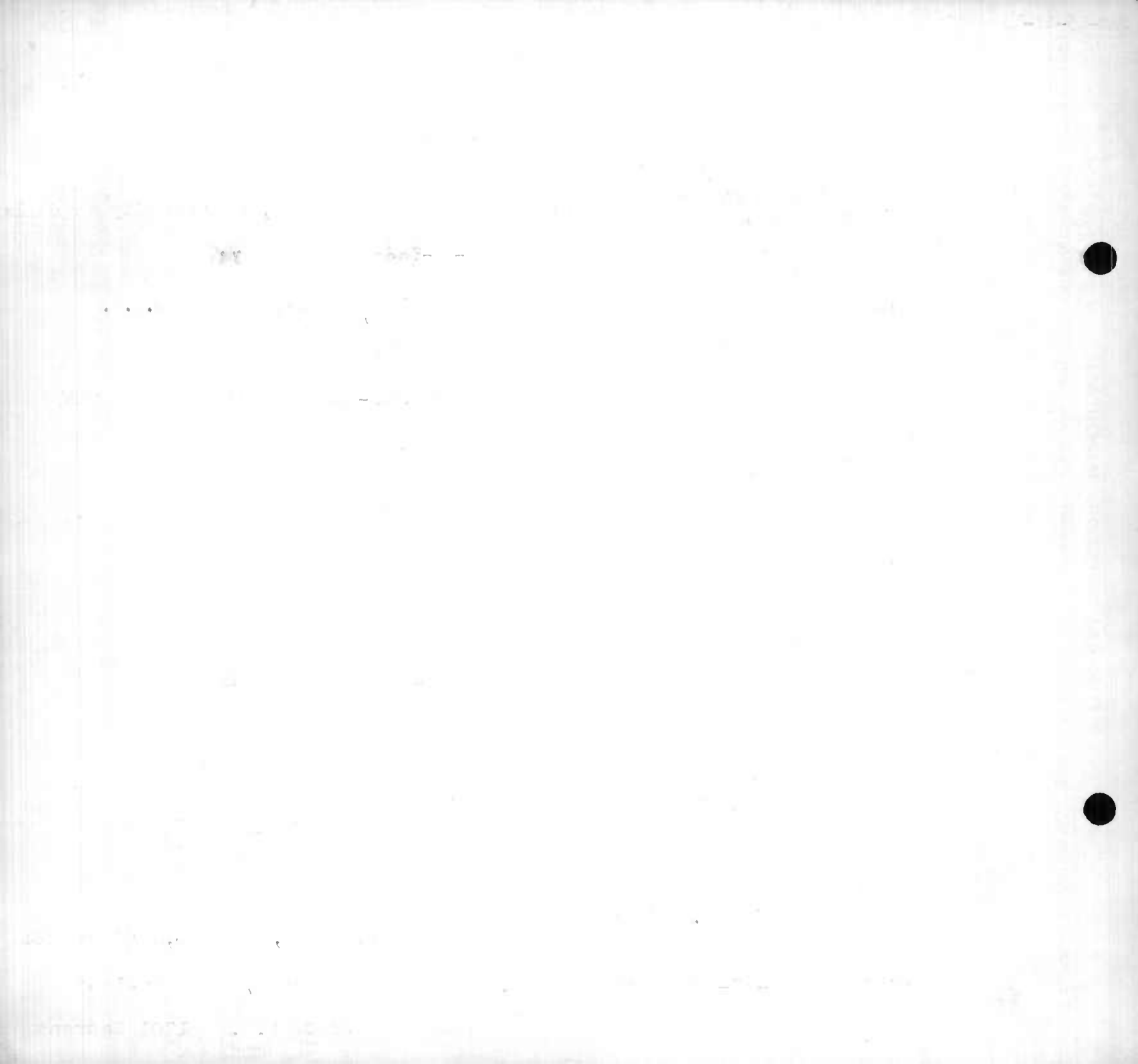
1944-1945
FACILITY

1944-1945

1944-1945

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-------------------------|---|--|--|--|--|--|
| BIRTH NO. P-500 | | 67 10086 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10086 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) Payne, David | | | |
| 2. DATE AND HOUR OF DEATH
10-21-67 19:15 H M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | | A. STATE Maryland
B. COUNTY Baltimore | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | D. STREET ADDRESS (If rural, give location)
4940 Eastern Avenue, Baltimore City Hospitals 21224 | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
Married | | 8. DATE OF BIRTH
1-30-1893 | 9. AGE (In years last birthday)
74 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Georgia Eastland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Allen PAYNE | | | | 14. MOTHER'S MAIDEN NAME
MATTIE PAYNE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Records: BCM-4940 Eastern Avenue 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
177X I | | | | CAUSE OF DEATH
(A) Carcinoma of Prostate
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2-10-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ca of Prostate | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-4 19 66 to 10-21 19 67 , that (I) (we) last saw the deceased alive on 10-21- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Roy S. Weiner | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10-21-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Roy S. Weiner | | | | 23D. ADDRESS
M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-25-67 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Mem. Park | | 24D. LOCATION (City, town, or county) (State)
Arbutus, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 23 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
MORTON & DYETT F.H. 1701 Laurens | | | |



B-652

67 10087

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10087

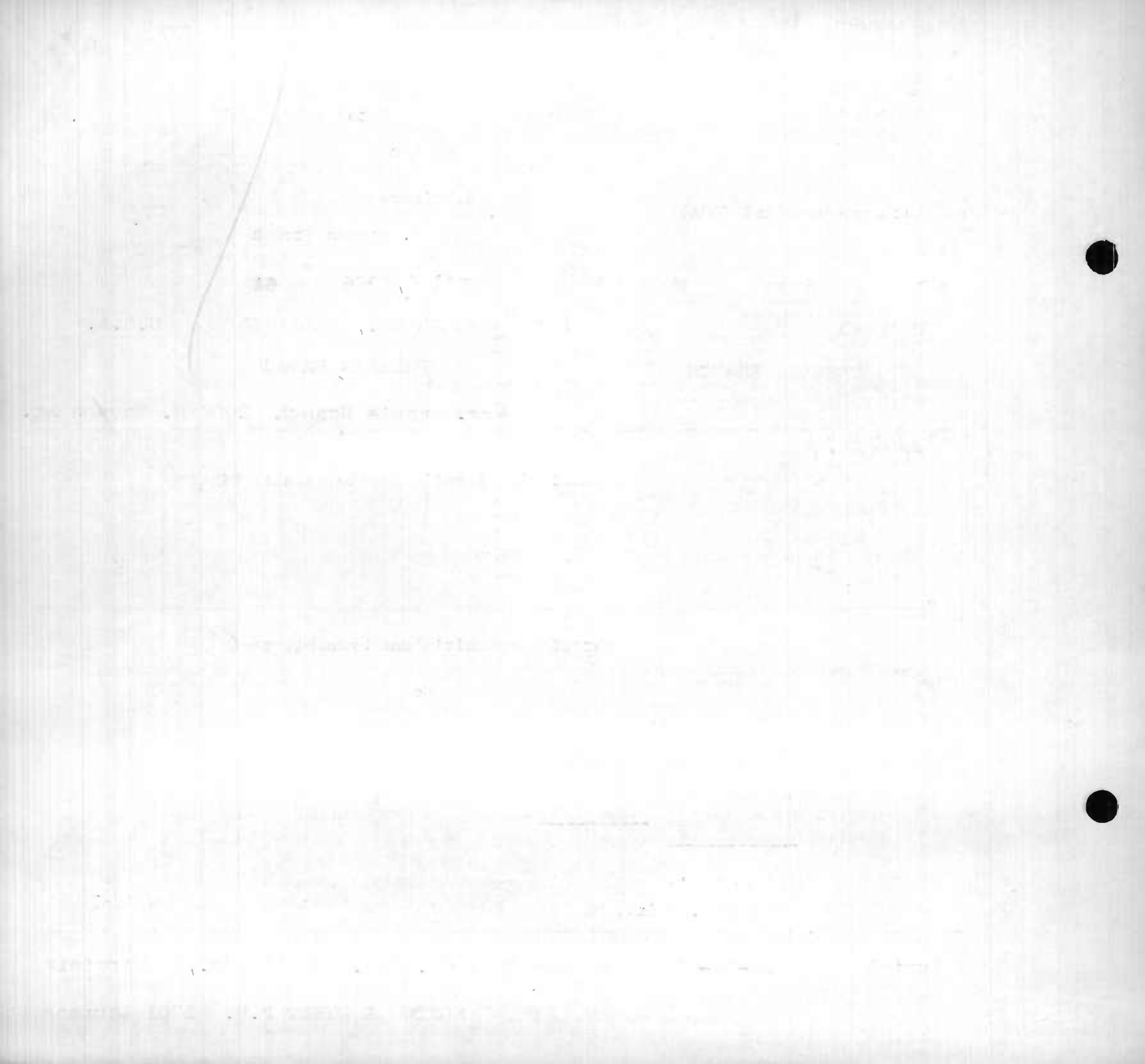
BIRTH NO.

M.E. CASE NO.

| | | | |
|---|-------------------------|---|---|
| 1. NAME OF DECEASED
(Type or Print)
ARMSTRONG | | 2. DATE AND HOUR PRONOUNCED DEAD
October 20, 1967 6:50 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

Lutheran Hospital (DOA) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2004 N. Payson Street | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
April 6, 1906 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (in years last birthday)
61 |
| 13. FATHER'S NAME
EMPRESS BRANCH | | 11. BIRTHPLACE (State or foreign country)
AMELIA CO., VIRGINIA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 17. INFORMANT
Mrs. Fannie Branch | | ADDRESS
2004 N. Payson St. | |

| | | | | |
|--|---|---|--|--|
| MEDICAL CERTIFICATION | 18. CAUSE OF DEATH
422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic Cardiovascular Disease
(A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| | ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO | | | |
| | (C) DUE TO | | | |
| | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic Bronchitis and bronchiectasis | | | |
| | 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| | 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| | ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Werner U. Spitz, MD | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
10/21/67
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| | 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 23B. DATE
10-24-67 | 23C. NAME of CEMETERY or CREMATORY
Good Hope Bapt Ch. Cem. Amelia Co., Virginia | 23D. LOCATION (City, town, or county) (State) |
| 24A. DATE RECEIVED BY HEALTH DEPT.
OCT 23 1967 | 24B. NAME OF REGISTRAR
Robert E. Finkbeiner | 24C. FUNERAL DIRECTOR ADDRESS
MORTON & DYETT F.H. 1701 Laurens St | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| C-462 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10088 | |
| BIRTH NO. Balto. Co. Md. 67 10088 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | Ralph Milton Clarke | | 10/21/67 11:50 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| 38 University Hospital | | MARYLAND | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| M | | W | | INFANT | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Balto., Maryland. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Ralph W. Clarke Jr. | | Audrey A. Klawnsmeier | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | |
| 18. 053.41 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) DUE TO | | Septicemia | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO | | | |
| ANTECEDENT CAUSES | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 9/30 1967 to 10/21 1967 | | | |
| that (I) (we) last saw the deceased alive on | | 10/21 1967 and that in (my) (our) opinion death occurred on the date | | | |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Rexnaldo O. Guzman M.D. | | 10/22/67 6:30 PM | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| REXNALDO O. GUZMAN M.D. | | University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 10-23-67 | | HOLY REDEEMER Co. | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. LOCATION | | | |
| 4430 Belair Rd. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| OCT 23 1967 | | Robert E. Farley M.E. | | Frank Deasnoce 3225 High St | |

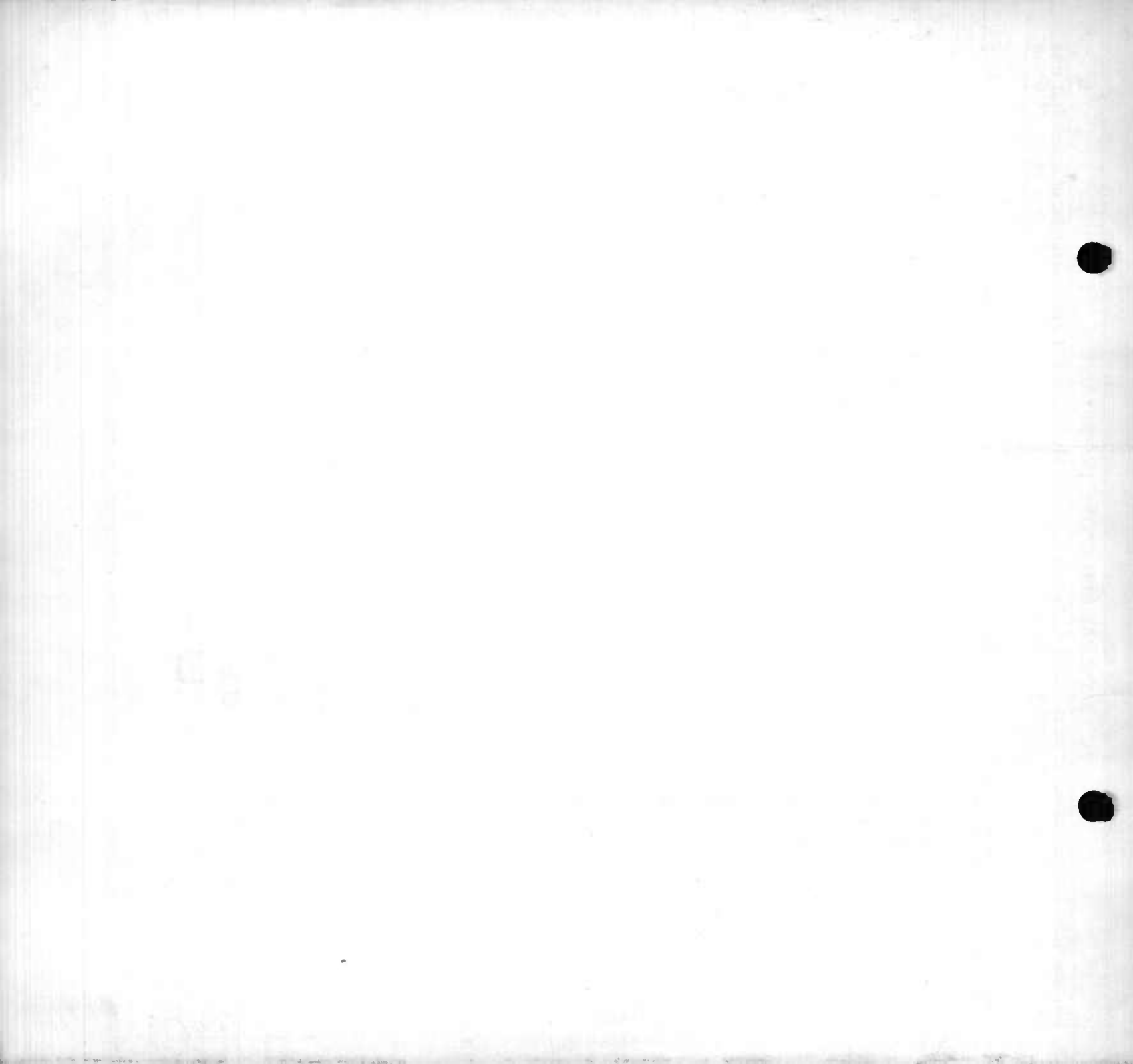
12-00-01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 10089 | |
|---|---------------------|---|---|--|---|
| CERTIFICATE OF DEATH | | | | Registered No. _____ | |
| BIRTH NO. <u>7-512</u> | | M.E. CASE NO. <u>67 10089</u> | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Mattie Kate Thompson</u> | | | 2. DATE AND HOUR OF DEATH
<u>October 22</u> <u>4 45</u> A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>38 University Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD.</u>
B. COUNTY _____
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>
D. STREET ADDRESS (If rural, give location) <u>810 W. Fayette St</u> | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>C</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>3-14-14</u> | 9. AGE (In years last birthday)
<u>53</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>H/W</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>VA.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | 13. FATHER'S NAME
<u>Henry Austin</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>Virginia Sheppardson</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
<u>Rev. Paul Thompson</u> | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>330 XI</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH
(A) <u>Aspiration of vomitus</u> <u>30 minutes</u>
(B) <u>Subarachnoid Hemorrhage</u> <u>10 hrs.</u>
(C) <u>Ruptured aneurysm</u> <u>10 hrs.</u> | | |
| 19A. DATE OF OPERATION
<u>D</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/21</u> <u>19 67</u> to <u>10/22</u> <u>19 67</u> , that (I) (we) last saw the deceased alive on <u>10/22</u> <u>19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Gary M. Lattin</u> | | | | 23B. DATE SIGNED
<u>10/22/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>GARY M. LATTIN</u> | | 23D. ADDRESS
<u>University Hospital - Baltimore</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>10-26-67</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Hd. Auburn Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>BALTO. MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 23 1967</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Fairbank</u> | | 25C. FUNERAL DIRECTOR
<u>Kelton Edmund Stone</u> | | | |
| 25D. ADDRESS
<u>1348 Calhoun</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|---|--|--|--|
| C-514 | | 67 10090 | | 67 10090 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| EVELYN CAMPBELL | | OCT. 20, 1967 | | 5 ³⁰ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Baltimore City Hospitals
4940 Eastern Ave.
Baltimore, Maryland # 21224 | | A. STATE
Maryland
8. COUNTY
Baltimore | | | |
| 5. SEX
Female | | 6. RACE
Negro | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
William Bush | | 14. MOTHER'S MAIDEN NAME
Mary Dyson | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
214-14-9525 | | 17. INFORMANT
BCH: Records 4940 Eastern Ave. Baltimore, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
DISEASE OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Urinary tract infection - sepsis
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
5 years
(1 week - anti) | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Hypertensive cerebral vascular disease | | 10 years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/8 1967 to 10/20 1967, that (I) (we) last saw the deceased alive on 10/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Benjamin Lechner, M.D. | | 23B. DATE SIGNED
Oct 20, 1967 | | | |
| 23C. PHYSICIAN'S NAME (Type)
BENJAMIN LECHNER | | 23D. ADDRESS
4940 Eastern Ave. Baltimore, Md.
Balt City Hosp. # 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-24-67 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Mem. Pk. | |
| 24D. LOCATION
Arbutus, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 23 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley | |
| 25C. FUNERAL DIRECTOR
Kelson Funeral Home | | 25D. ADDRESS
1348 Calhoun St. | | | |

V.S. 153

11-3-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10091 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10091 | |
|--|------------------|---|-----------------------------------|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| John Moore | | | | 10-22-67 | | 7:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)

Provident Hospital, Inc.
1514 Division Street
Baltimore, Maryland 21217 | | | | A. STATE
Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
1340 Druid Hill Avenue | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH
2-8-35 | 9. AGE (In years last birthday)
32 | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days | 12. Under 24 Hrs. Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Roosevelt Bowman - 1716 Wolfe St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | Hypoglycemia, isop.
alcoholism & D.Tune.
Asp. Pneumonia, Sec. | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from October 22, 1967 to October 22, 1967, that (I) (we) last saw the deceased alive on October 22, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>W. S. ...</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10-23-67 | |
| 23C. PHYSICIAN'S NAME (Type)
M. Mercado | | | | 23D. ADDRESS
M.D. 1514 Division Street Balto., Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-25-67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 23 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
Kelson Funeral Home - 1348 Calhoun St. | | ADDRESS | |

518 W.

N.C.

At present, the
College is in
the process of
expanding its
facilities to
accommodate the
increasing number
of students.

Respectfully,
[Signature]

P. 1981-90

Principal 1981-82 H. H. Johnson, Jr.

Johnston, H. H. (1981-82)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10092 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10092 | |
|--|---------------------|--|-------------------------------------|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) <i>Louis A. Parks</i> | | | | 2. DATE AND HOUR OF DEATH
<i>October 22 1967 2¹⁰ A M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>
<i>University of Maryland</i>
<i>38</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>MARYLAND</i>
B. COUNTY <i>BALTIMORE</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>13-03</i>
D. STREET ADDRESS (If rural, give location) <i>1520 RETREAT STREET</i> | | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>C</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>MARRIED</i> | 8. DATE OF BIRTH
<i>4-3-1911</i> | 9. AGE (In years last birthday)
<i>56</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>VIRGINIA</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>MOSES PARKS</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>FRAZIER LEWIS</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<i>215-09-3147</i> | | 17. INFORMANT
<i>MARGARET PARKS</i> | | ADDRESS
<i>SAME</i> | |
| 18. <i>161X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the immediate cause of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <i>CARCINOMA OF LARYNX</i>
DUE TO

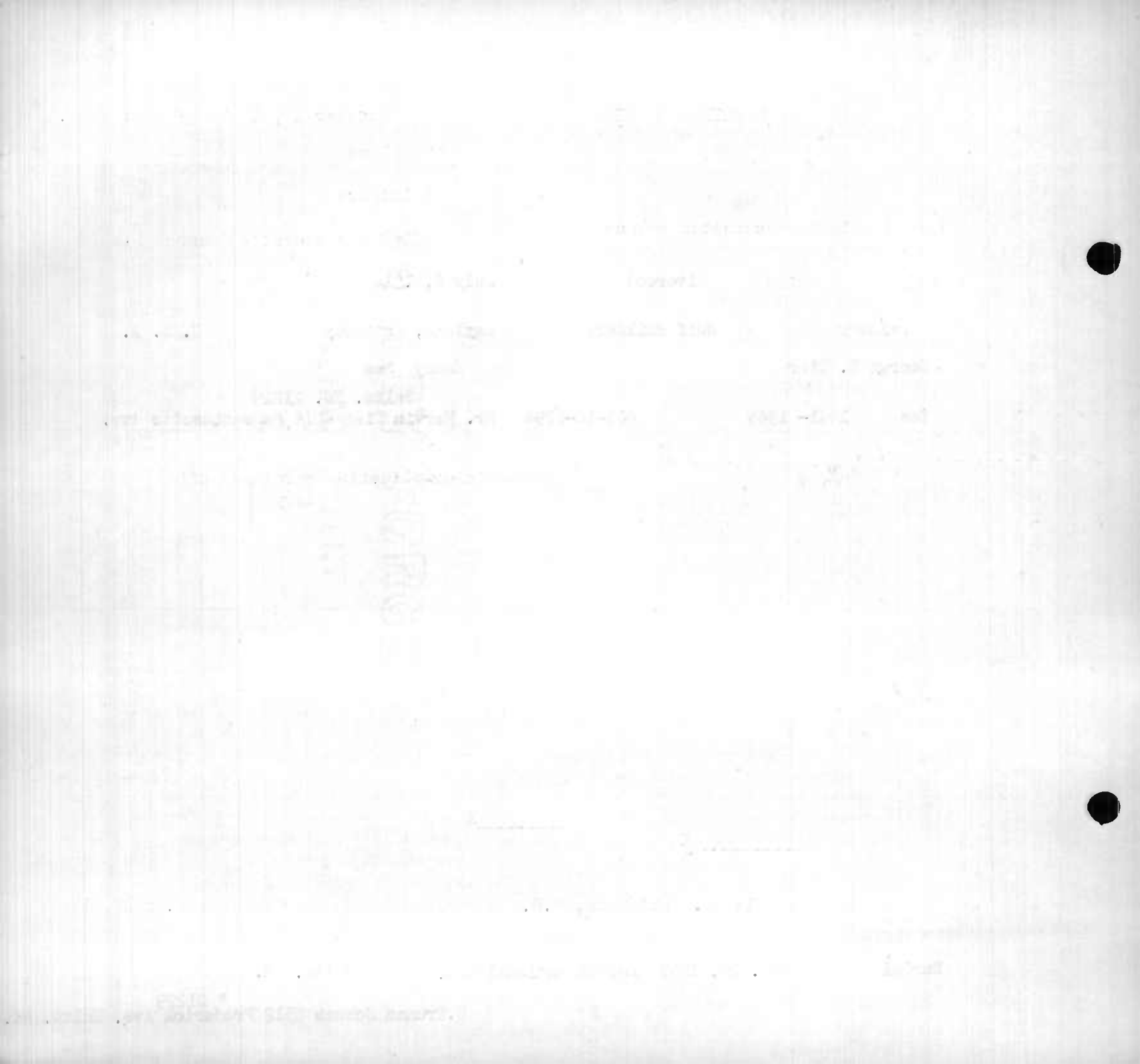
(B) _____
DUE TO

(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<i>6 MONTHS</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <i>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i> | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>OCTOBER 9</i> 19 <i>67</i> to <i>OCTOBER 22</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>OCTOBER 22</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Marion L. Talbot</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>10/22/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<i>10-26-67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Mt. Auburn Cem.</i> | | 24D. LOCATION (City, town, or county) (State)
<i>BALTO; MD.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 23 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, MD</i> | | 25C. FUNERAL DIRECTOR
<i>Kelson Funeral Home</i> | | ADDRESS
<i>1348 Calhoun St.</i> | |

James M. ...
...

James M. ...
...

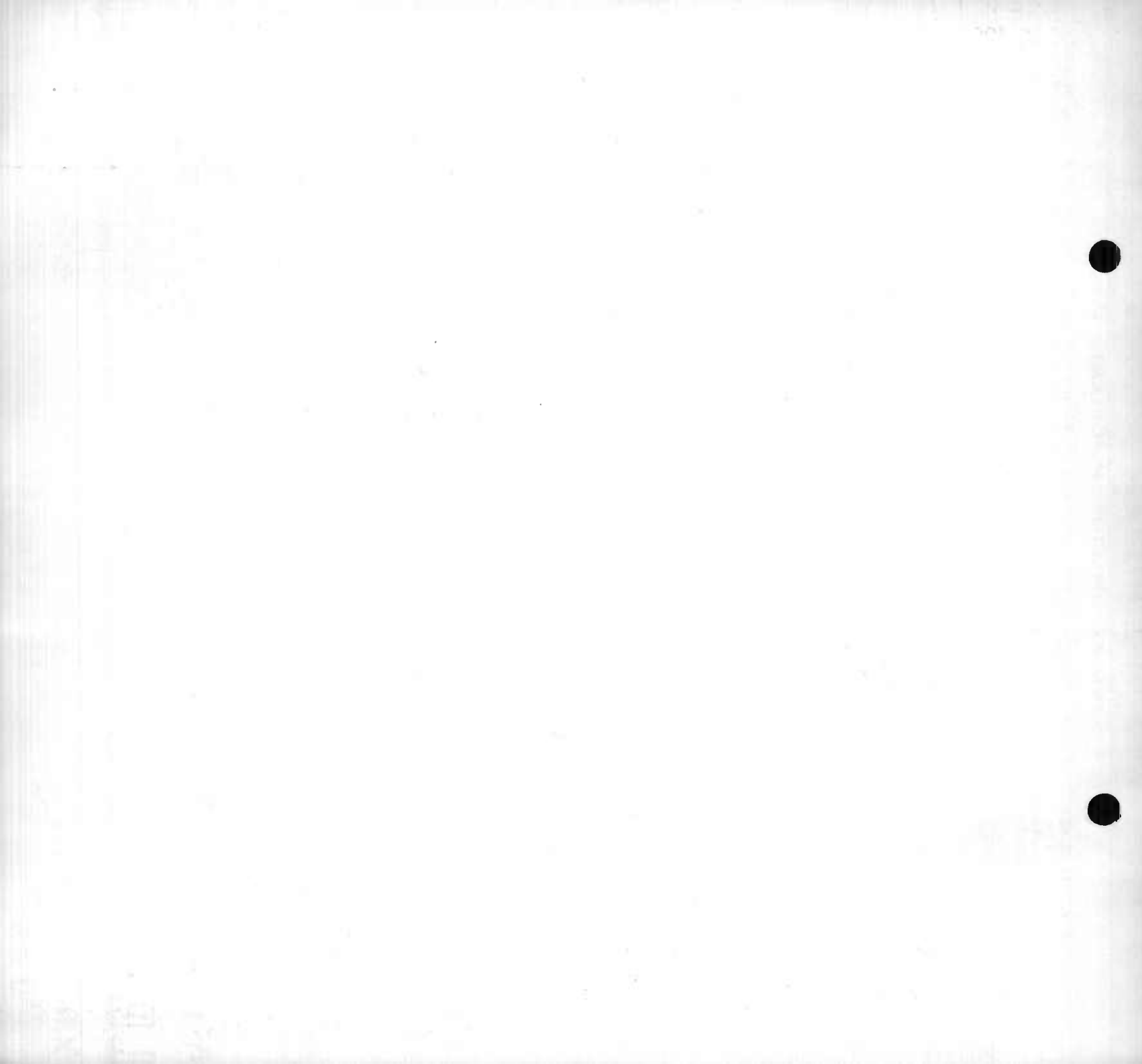
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
|---|---------|---|------------------|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| MARTIN TIER | | October 18, 1967 6:10 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE
Maryland | |
| 00 4016 Massachusetts Avenue | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore | |
| | | D. STREET ADDRESS (If rural, give location)
4016 Massachusetts Avenue | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| Male | White | Divorced | July 2, 1914 |
| 9. AGE (In years last birthday) | | 10. AGE (In years last birthday) | |
| 53 | | 53 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| Painter | | Ruff Builders | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Wayland, Kentucky | | U. S. A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| George B. Tier | | Nancy See | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Yes 1941- 1945 | | 403-18-6294 | |
| 17. INFORMANT | | ADDRESS | |
| Mr. Marvin Tier | | Balto. Md. 21229 4016 Massachusetts Ave. | |
| 18. CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | |
| Pneumonia complicating carcinoma of larynx | | | |
| ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 2 | | | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| | | | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| October 19, 1967 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | |
| Burial | | Oct. 20, 1967 | |
| 23C. NAME OF CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Loudon National Cem. | | Balto. Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| OCT 23 1967 | | Robert E. Farley, M.D. | |
| 24C. FUNERAL DIRECTOR | | ADDRESS | |
| G. Truman Schwab | | 21229 3512 Frederick Ave. Balto. Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10094 | |
|--|------------------|---|--|---|---|
| BIRTH NO. 67 10094 | | CERTIFICATE OF DEATH | | M.E. CASE NO. 260 829 | |
| 1. NAME OF DECEASED
(Type or Print) Earl Baltz Folmer | | | 2. DATE AND HOUR OF DEATH
October 21, 1967 5:10 a.m. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
U.S. Public Health Hosp. | | | A. STATE B. COUNTY
Rt. Hagerstown Md. | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Hagerstown Md Wash. Co. | | |
| | | | D. STREET ADDRESS (If rural, give location)
Rt. 1 71-00 | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER-MARRIED
WIDOWED, DIVORCED (Specify)
Yes | 8. DATE OF BIRTH
Sep 21/1922 | 9. AGE (In years lost birthday)
45 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Oil Burner Service Man | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Hagerstown | |
| 13. FATHER'S NAME
Russell Folmer | | | 14. MOTHER'S MAIDEN NAME
Reta Baltz | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
USA.T 18412787 | | | 17. INFORMANT
Himself | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
204.1 I
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) DUE TO
Myelogenous Leuk
(B) DUE TO
Left T Sub Dural Hematoma
(C) | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
None | | 21C. WHERE DID INJURY OCCUR?
If in Baltimore City, give exact location | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 6 1967 to Sept 21 1967, that (I) (we) last saw the deceased alive on Oct 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
George H. Greidinger | | | 23B. DATE SIGNED
Oct. 21/67 | | |
| 23C. PHYSICIAN'S NAME (Type)
George H. Greidinger | | | 23D. ADDRESS
U.S. Public Health Hosp | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/23/67 | | 24C. NAME OF CEMETERY or CREMATORY
Rest Haven Cemetery Hagerstown Md. | |
| 24D. LOCATION (City, town, or county) (State)
Hagerstown Md. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 23 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fink | |
| 25C. FUNERAL DIRECTOR
Past Haven Funeral Chapel | | 25D. ADDRESS
1601 Penna Ave | | 25E. ADDRESS | |



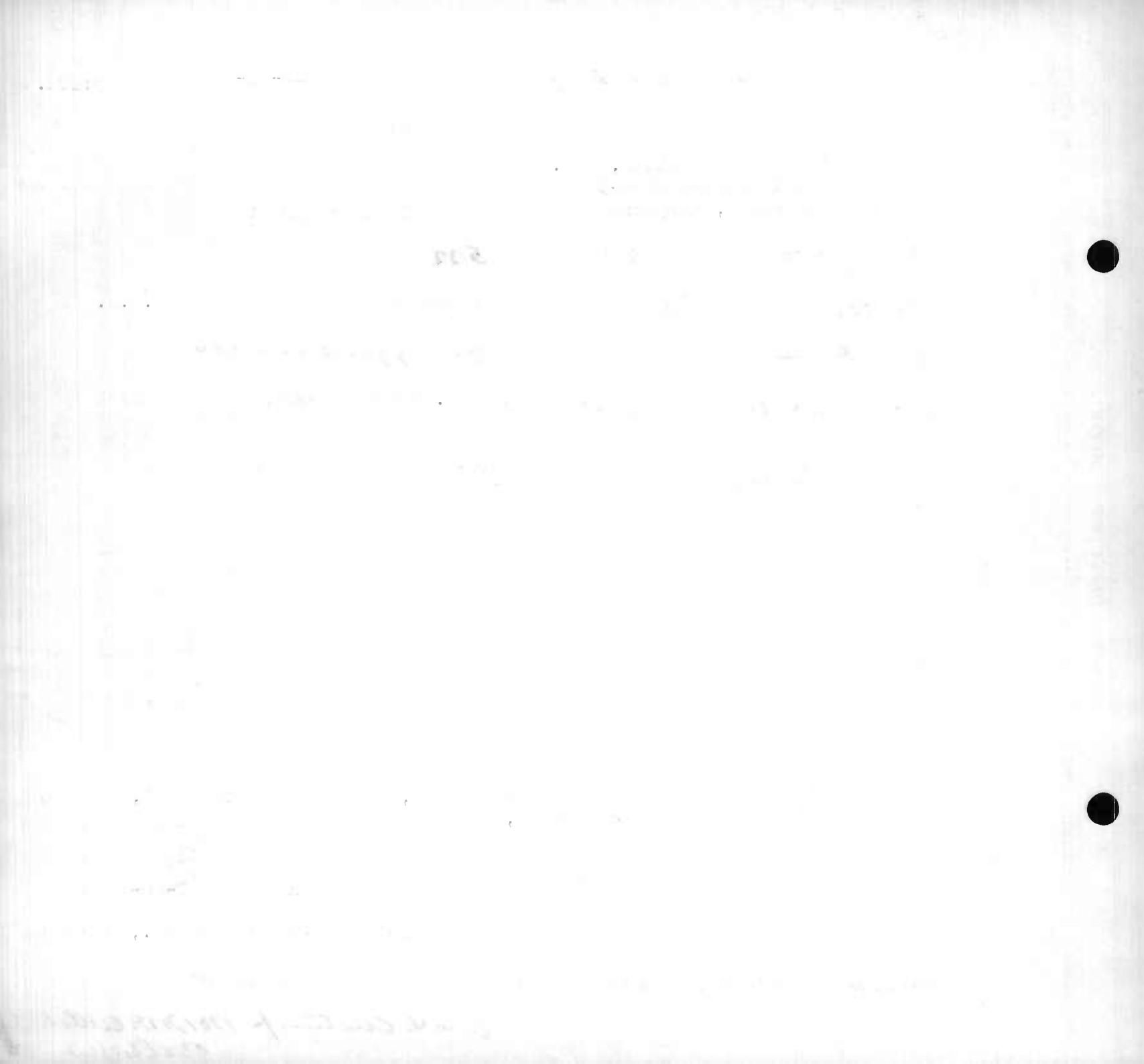
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|---|---|--|
| <div style="display: flex; justify-content: space-between;"> V-242 67 10095 BALTIMORE CITY HEALTH DEPARTMENT </div> | | <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH Registered No. 67 10095 </div> | |
| BIRTH NO.
M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH
<div style="display: flex; justify-content: space-between;"> Albert Vessells, SR. 10-19-67 9:10 P.M. </div> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

<div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION
 39
 PROVIDENT HOSPITAL, INC.
 1514 DIVISION STREET
 BALTIMORE, MARYLAND 21217 </div> <div> (If not in hospital or institution, give street address or location) </div> </div> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
<div style="display: flex; justify-content: space-between;"> <div> A. STATE
 Maryland
 C. CITY OR TOWN (If outside city limits, write RURAL and give township)
 Baltimore
 D. STREET ADDRESS (If rural, give location)
 1730 Division Street </div> <div> B. COUNTY
 14-02 </div> </div> | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
5/24/08 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Porter | | 10B. KIND OF BUSINESS OR INDUSTRY
Stores | 9. AGE (In years last birthday)
59 |
| 13. FATHER'S NAME
unb | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes W.W. II | | 16. SOCIAL SECURITY NO.
218-09-7507 | 17. INFORMANT
Mrs. Mildred Vessells |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
(A) Cerebro-Vascular Accident
DUE TO
(B) DUE TO
(C) | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from October 12, 19 67 to October 19, 19 67, that (I) (we) last saw the deceased alive on October 19, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Gregorio S. Tenoco | | 23B. DATE SIGNED
10-20-67 | |
| 23C. PHYSICIAN'S NAME (Type)
GREGORIO S. TENOCO | | 23D. ADDRESS
1514 Division Street Balto., Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
10/25/67 | 24C. NAME of CEMETERY or CREMATORY
Balto. Nat. | 24D. LOCATION (City, town, or county) (State)
Balto. Md |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 23 1967 | 25B. NAME OF REGISTRAR
Robert E. Farber | 25C. FUNERAL DIRECTOR
Wm. P. Clifton | ADDRESS
1701 M.E. Lullo St Balto. Md |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10096

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIE GRAY

2. DATE AND HOUR PRONOUNCED DEAD

October 17, 1967 6:55 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 2016 N. Pulaski St. D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 2016 N. Pulaski St.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

8 -26-89

9. AGE (in years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Gray

14. MOTHER'S MAIDEN NAME

Ida Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Md.

Janice Dawkins 2016 Pulaski St. Balto

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma of the prostate

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 18, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

10-21-67

23C. NAME of CEMETERY or CREMATORY

Brooks Ch. Cem

23D. LOCATION

Mutual

(City, town, or county) (State)

Cal. Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

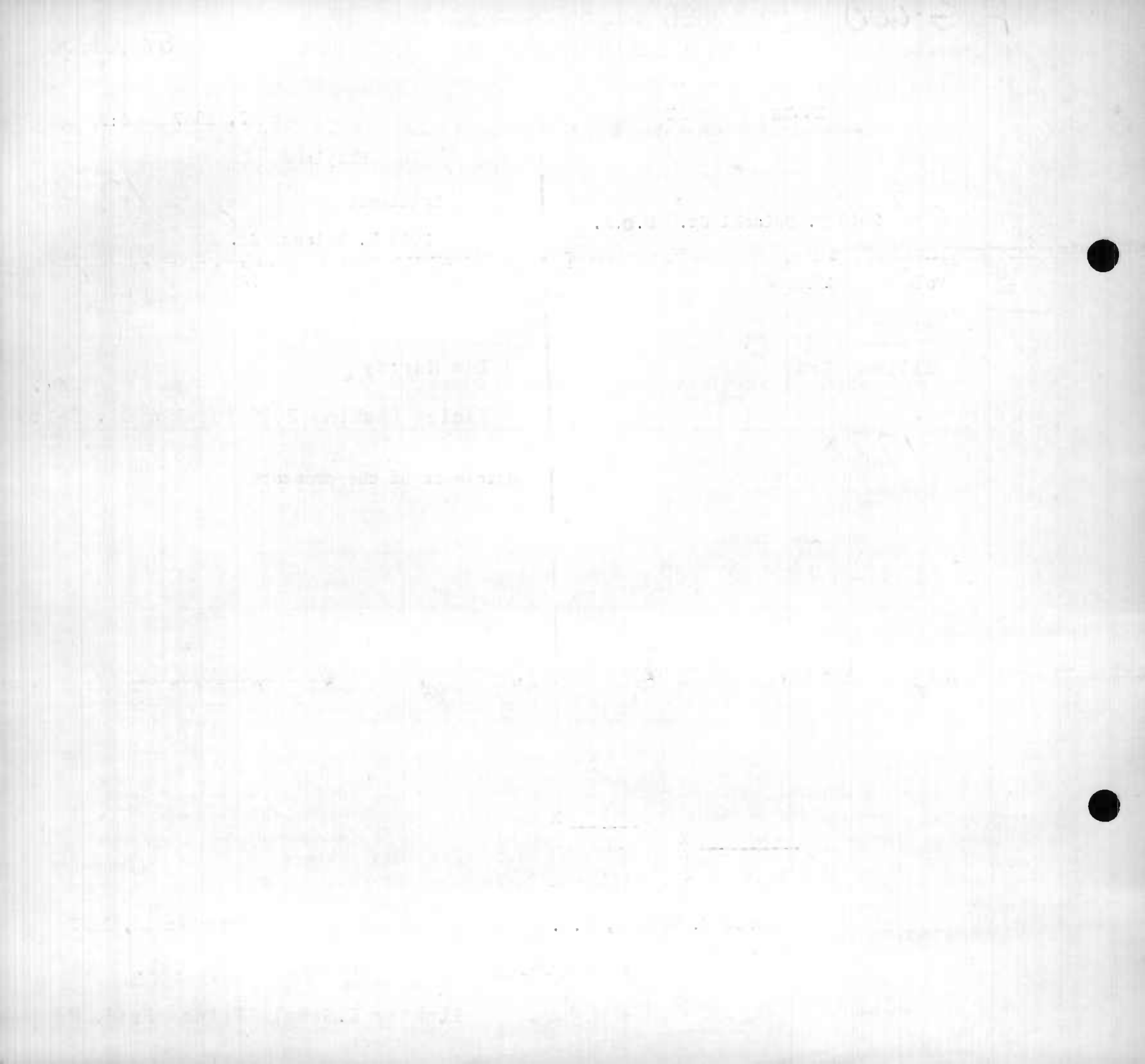
24C. FUNERAL DIRECTOR

ADDRESS

OCT 23 1967

Robert E. Farley

Pinkney E. Sewell Prince Fred. Md



CERTIFICATE OF DEATH

Registered No.

67 10097

BIRTH NO. 67-21004 67 10097

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Langenfelder, Carlene, Baby Girl

2. DATE AND HOUR OF DEATH

10/17/67

11:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION
(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

921 Garden Drive

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never married

8. DATE OF BIRTH

10/13/67

9. AGE (In years
lost birthday)If Under 1 Yr. (If Under 24 Hrs.
Months Days Hours Min.

4

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard

14. MOTHER'S MAIDEN NAME

Carlene Hunt

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

BCH: Records 4940 Eastern Ave. Baltimore, Md. #21224

18. 760.5 I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) ? intra-ventricular hemorrhage ~ 3d.
DUE TO(B) prematurity
DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.acidosis, hypoxia, ~~and~~ shock

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? YES21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At
Work ☐Not While
At Work ☐22. I certify that (I) (this hospital) attended the deceased from 10/13/67 19 to 10/17/67 19
that (I) (we) last saw the deceased alive on 10/17/67 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) did (did not) view the body after death.

23A. SIGNATURE

H. William Taeusch, Jr.

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

10/17/67

23C. PHYSICIAN'S
NAME (Type)

H. William Taeusch, Jr.

M.D.

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Ave. Baltimore, Maryland #2122424A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Cremation

10-19-67

BALTIMORE CITY HOSPITALS BALTIMORE, MARYLAND 21224

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

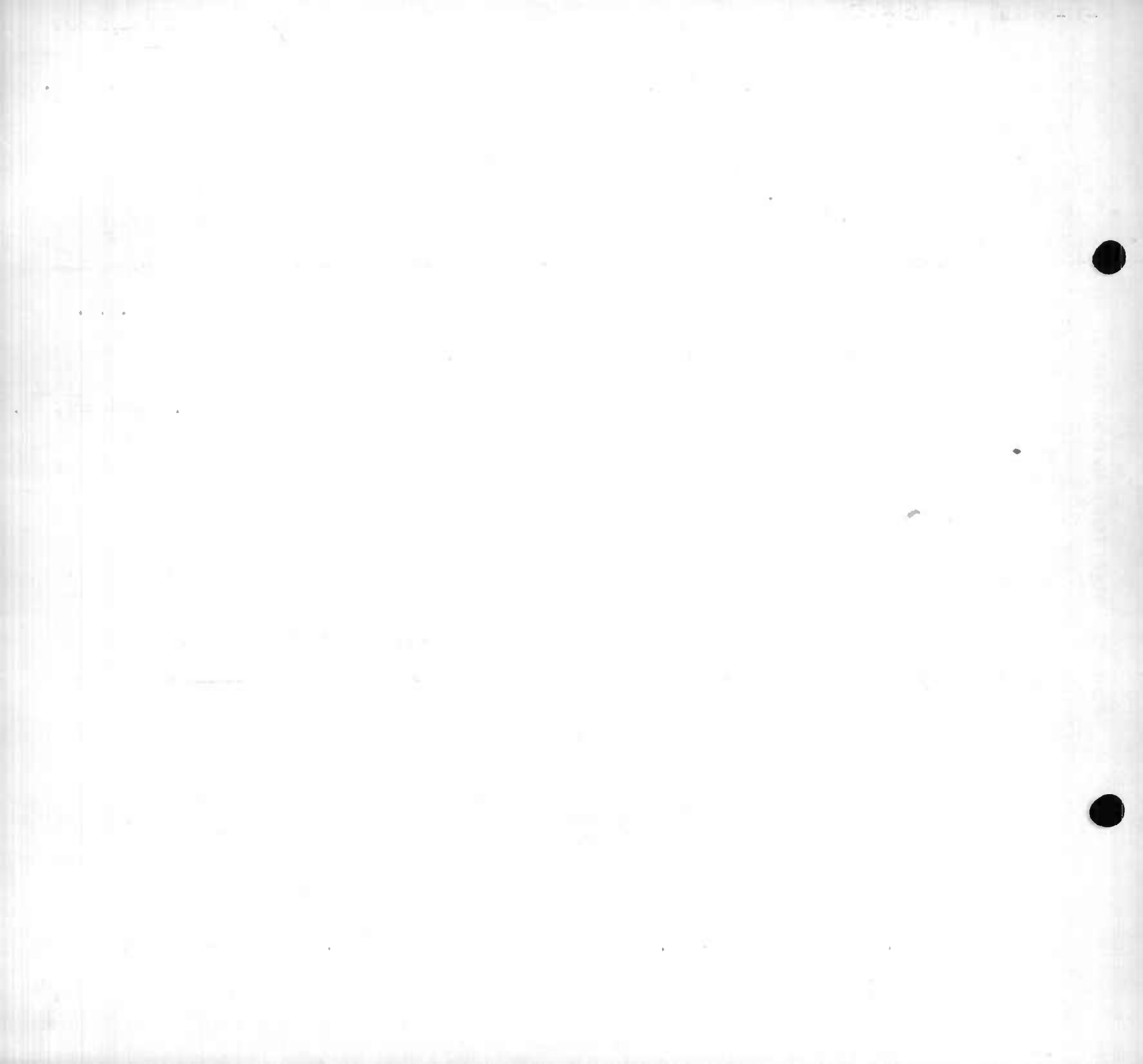
OCT 23 1967

Robert E. Fairbank

HOSPITAL DISPOSAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|----------------------|---|-------------------------------------|---|-------------------------------|---|--|
| BIRTH NO. G-616 | | 67 10098 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10098 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) GRUVER, ANNA M | | | |
| 2. DATE AND HOUR OF DEATH
10/20/67 8:15 A.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
THE JOHNS HOPKINS HOSPITAL,
BALTIMORE, MARYLAND - 21205 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania
B. COUNTY York
C. CITY OR TOWN (If outside city limits, write RURAL and give township) York
D. STREET ADDRESS (If rural, give location) 469 W. King S. E. | | | |
| 5. SEX
F. | 6. RACE
W. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
10-15-93 | 9. AGE (In years lost birthday)
74 | If Under 1 Yr.
Months Days | If Under 24 Hrs.
Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
York, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William Lauer | | | | 14. MOTHER'S MAIDEN NAME
Amanda Bentzel | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
B No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Charles I. Janis | | ADDRESS
1515 East Philadelphia st
York, Pa. | |
| 18. 193.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Melastatic Tumor @ Cerebellum.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Cachexia. | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
3 weeks. | |
| MEDICAL CERTIFICATION | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
Oct 19, 1967 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Melastatic Tumor @ Cerebellum | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 14 , 19 67 to Oct 20 , 19 67 , that (I) (was) last saw the deceased alive on Oct 20 , 19 67 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
C. Bhushan | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
Oct 20, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
CHHABI BHUSHAN | | M.D. | | 23D. ADDRESS
The Johns Hopkins Hospital
Baltimore, Md - 21205 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/23/67 | | 24C. NAME of CEMETERY or CREMATORY
Greenmount Cemetery | | 24D. LOCATION (City, town, or county) (State)
York, Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR
Wm. Cook-Brooks Inc. Balto. Md. 21202 | | ADDRESS | |

THE TOWN OF BOSTON
BOSTON, MASSACHUSETTS

F
W

WILLIAM B. BOSTON
BOSTON, MASSACHUSETTS

WILLIAM B. BOSTON
BOSTON, MASSACHUSETTS

W

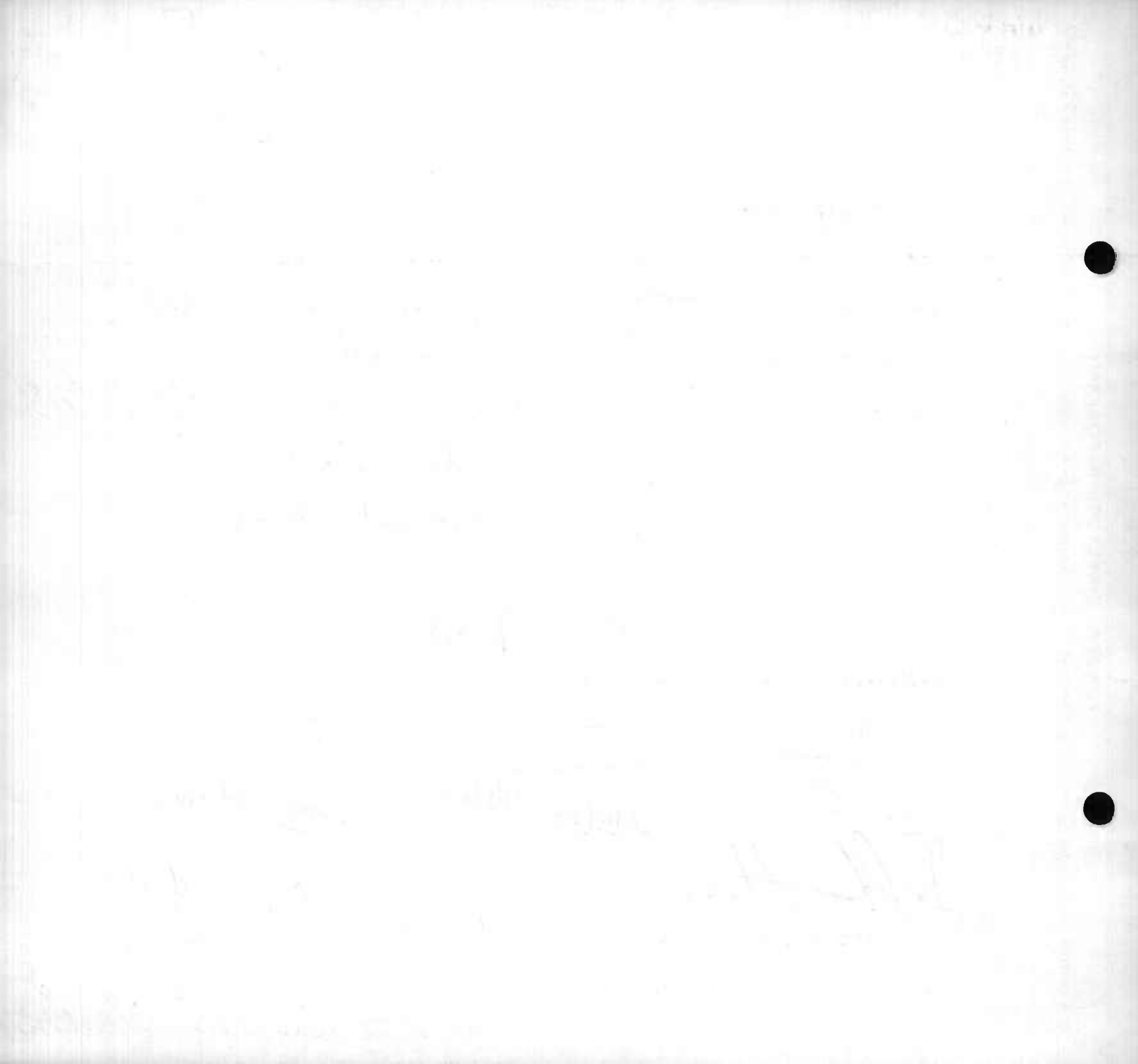
WILLIAM B. BOSTON
BOSTON, MASSACHUSETTS

WILLIAM B. BOSTON
BOSTON, MASSACHUSETTS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|---|--|---|------------------------------|
| 67 10099 | | CERTIFICATE OF DEATH | | 67 10099 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | Martin Kraeski | | Oct 14, 1967 1:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| 38 University Hospital | | Md. | | Savage | |
| Balt Md | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Savage | |
| | | D. STREET ADDRESS (If rural, give location) | | 63-00 | |
| | | 405 Baltimore St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| M | W | married | 8/13/17 | 50 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Painter | | US Govt Farm | | Highbridge, Laurel Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Martin J. Kraeski | | Mary Catherine Clark | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| unknown | | 579-12-8038 | | Mrs. Dorothy Kraeski | |
| 18. CAUSE OF DEATH | | 19. INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) DUE TO | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO | | | |
| ANTECEDENT CAUSES | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Perforated Duodenum | | | |
| | | subdiaphragmatic abscess | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | General Peritonitis | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 9/14/67 | ruptured Duodenum | yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| NO | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/8/67 to 10/14/67, that (I) (we) lost saw the deceased alive on 10/14/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Jeffrey Stier | | | | 10/14/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| JEFFREY STIER | | U of Md. Hosp. BALTO, MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) | |
| Buried | 10/17/67 | St Mary Cem | Laurel Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | ADDRESS | | |
| 10/17/67 | Robert E. Stier | St. Witt | Laurel Md | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|------------------------------------|---|---|
| J-250
BIRTH NO. 67 10100 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10100 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Joseph J. JACKSON | | 2. DATE AND HOUR OF DEATH
3:58 AM 10/20/67 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location)
202 N. FREMONT AVENUE 21201 | |
| 5. SEX
MALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
1-16-84 | 9. AGE (In years last birthday)
83 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER (R) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
VA. | |
| 13. FATHER'S NAME
THOMAS JACKSON | | 14. MOTHER'S MAIDEN NAME
MARTHA JACKSON | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
217-05-3074 | | 17. INFORMANT ADDRESS
EVELYN Foster 1113 ORLEANS ST | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
152.01 | | CAUSE OF DEATH
(A) SEPSIS
DUE TO
(B) PNEUMONIA
DUE TO
(C) CARCINOMA DUODENUM | | INTERVAL BETWEEN ONSET AND DEATH
4 days
4 days
6 mo | |
| 18. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 7 19 67 to Oct 20 19 67 , that (I) (we) last saw the deceased alive on Oct 20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
G. H. Reed | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/20/67 | |
| 23C. PHYSICIAN'S NAME (Type)
GEORGE H REED | | M.D. | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10/24/67 | | 24C. NAME OF CEMETERY or CREMATORY
MT. AUBURN CEM. | |
| 24D. LOCATION (City, town, or county) (State)
BALTO. MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 23 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farkner | | 25C. FUNERAL DIRECTOR
Joseph J. Rock | |
| | | | | ADDRESS
1304 N. Central | |

1-10-14

78

(2) 820000

11

11

275000

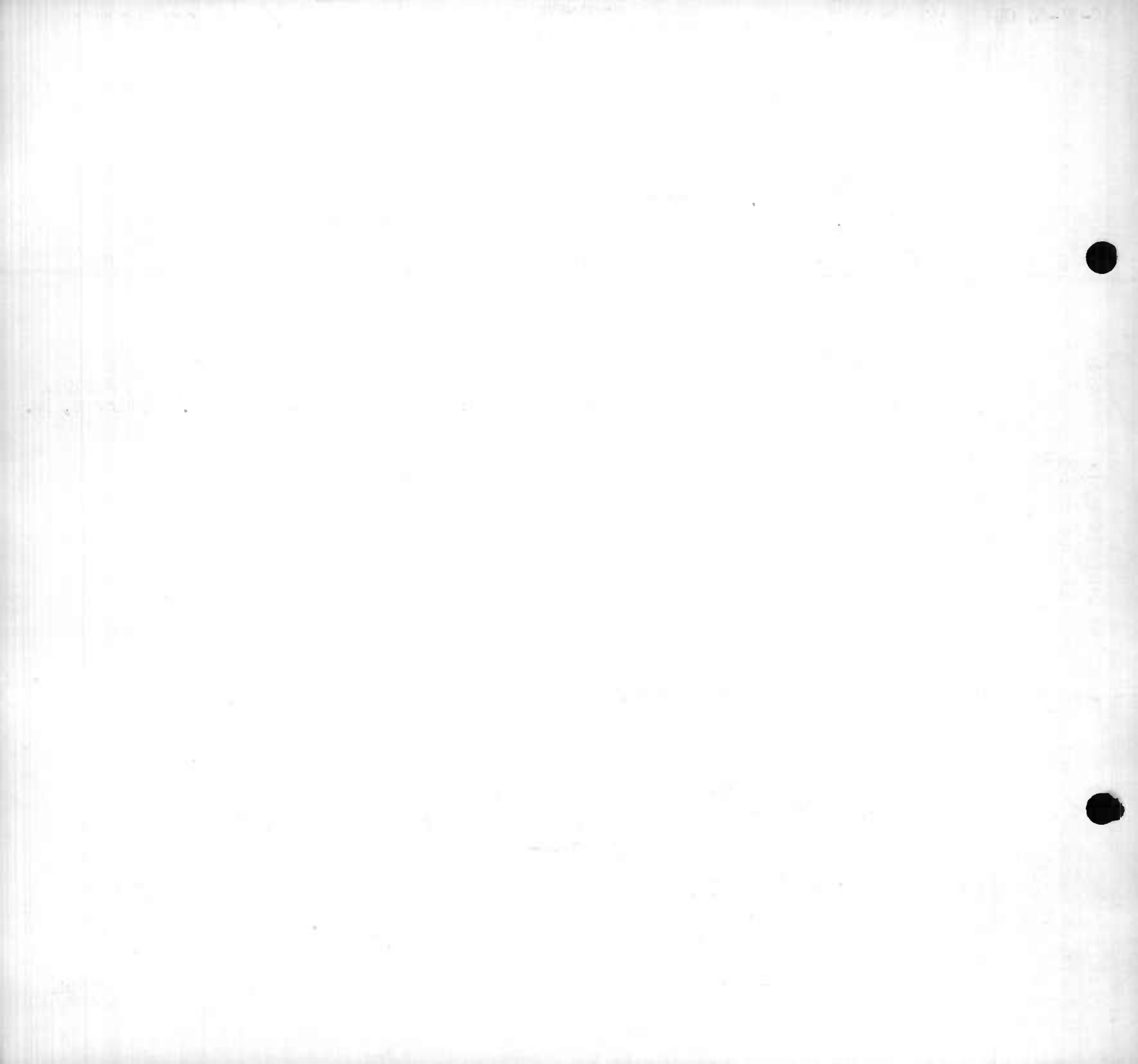
275000

275000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|------------------------------------|--|--|
| BIRTH NO. 67-1995 267 10101 | | CERTIFICATE OF DEATH | | Registered No. 67 10101 4 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Etta
BABY BOY / BROWN | | 2. DATE AND HOUR OF DEATH
10/8/67 2:00 P.M. | |
| 3. PLACE OF DEATH (IN BALTIMORE, MARYLAND) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY G.A.C. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 52-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALTIMORE CITY HOSPITAL
4940 Eastern Ave.
Baltimore, Maryland # 21224 | | D. STREET ADDRESS (If rural, give location)
331 DUPONT AVENUE | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never married | 8. DATE OF BIRTH
10/7/67 | 9. AGE (In years last birthday)
18 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Not Given | | 14. MOTHER'S MAIDEN NAME
ETTA ELEANOR BROWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
0 | | 17. INFORMANT ADDRESS
BCH: Records 4940 Eastern Ave. Baltimore, Md. # 21224 | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ASPHYXIA
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/7 19 67 to 10/8 19 67 that (I) (we) last saw the deceased alive on 10/8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joerg Winterer | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/8/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Joerg Winterer | | 23D. ADDRESS
4940 Eastern Ave.
Baltimore, Maryland # 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
CREMATION | | 24B. DATE
10-12-67 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE CITY HOSPITAL | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND 21224 | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
HOSPITAL DISPOSAL | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

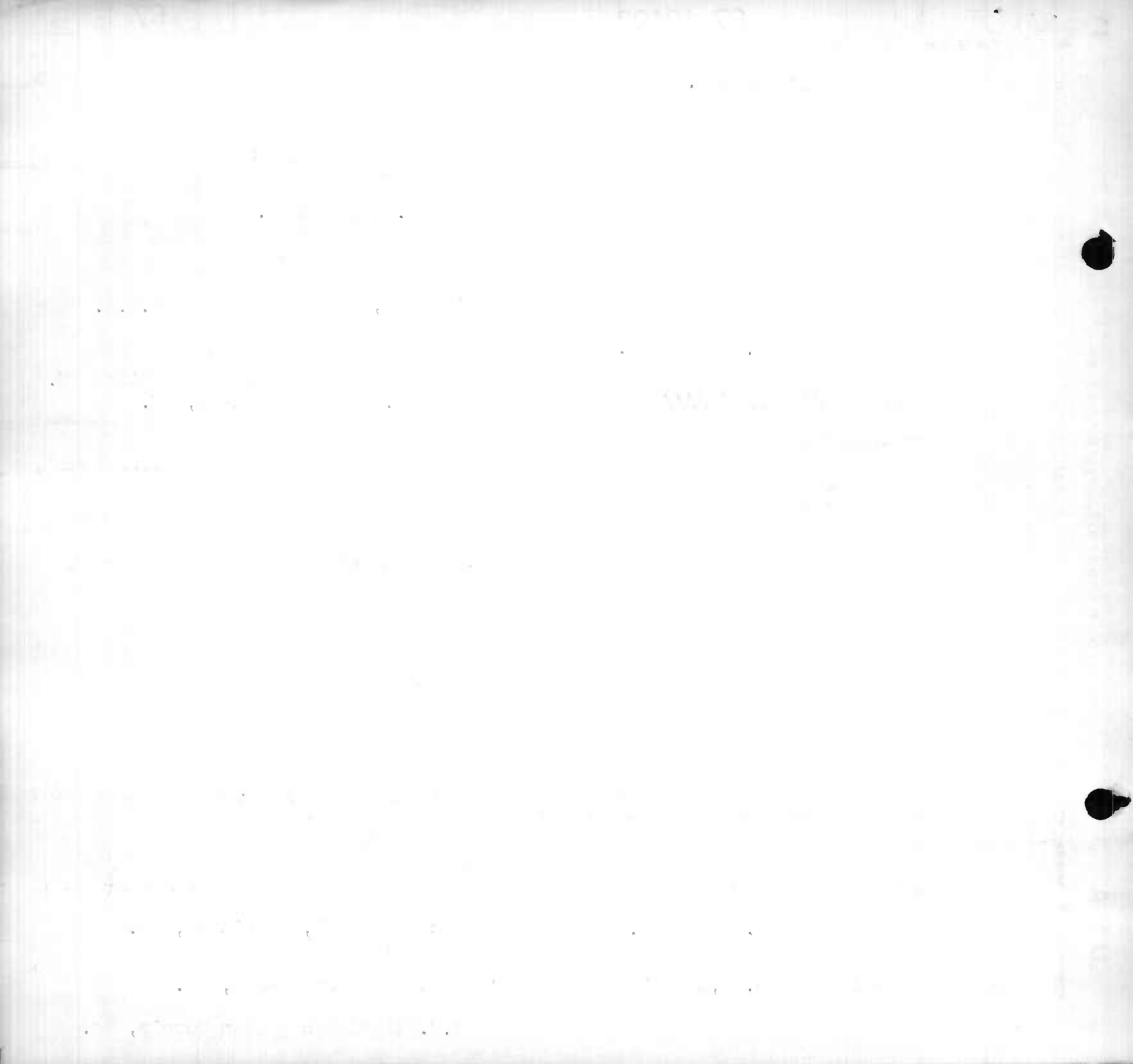
| | | | | | |
|---|------------------|--|----------------------------|--|---|
| BIRTH NO.
67 10102 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10102 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) DUPREE, Young | | 2. DATE AND HOUR OF DEATH
October 20, 1967 9:15 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
CERTIFICATE AMENDED
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
27 Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY Harford Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Aberdeen
D. STREET ADDRESS (If rural, give location)
10 Dorsey Street | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
3/6/96 | 9. AGE (In years lost birthday)
71 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Railroad Trackman | | 10B. KIND OF BUSINESS, OR INDUSTRY
Balto. & Ohio R.R.
Penn. Railroad | | 11. BIRTHPLACE (State or foreign country)
Dillon, S.C. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Simon Dupree | | 14. MOTHER'S MAIDEN NAME
Manda Patterson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 7/16/18 - 3/29/19 | | 16. SOCIAL SECURITY NO.
705-09-9054 | | 17. INFORMANT
VA Hospital Records
3900 Loch Raven Blvd., Balto., Md. 21218 | |
| 18. 15381
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Pneumonia ? Aspiration
DUE TO
Advanced Cancer of Colon
(B) DUE TO With liver metastasis
(C) | | INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Jaundice & old age | | | |
| 19A. DATE OF OPERATION
10/9/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Obstr. Jaundice & Cancer of Colon NO | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from September 27th 19 67 to October 20th 19 67, that (X) (we) last saw the deceased alive on October 20th 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE
El-Bayadi | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
October 20, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
El-Bayadi | | 23D. ADDRESS
Veterans Administration Hospital
3900 Loch Raven Blvd., Balto., Md 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-23-67 | | 24C. NAME OF CEMETERY or CREMATORY
Union Methodist Cemetery, Aberdeen, Maryland | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
Harrington Funeral Home, Aberdeen, Md | | | |

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|--------------|--|----------------------------|--|--------------------------------|
| BIRTH NO. | | 67 10103 | | 67 10103 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | James V. German | | 2. DATE AND HOUR OF DEATH
10-21-67 11:40 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
Maryland | | B. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| 37 Mercy Hospital | | Baltimore | | 11-01 | |
| D. STREET ADDRESS (If rural, give location) | | 920 N. Calvert St. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married | 8. DATE OF BIRTH
8-5-21 | 9. AGE (In years last birthday)
46 | 10. If Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired | | Unknown | | Elkridge, Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Thomas S. German Sr. | | Oaisey Delores Brown | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | unknown | | 906 Timber Ridge Rd.
Thomas S. German Hanover, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 331X I | | (A) PULMONARY EMBOLISM | | MINUTES | |
| ANTECEDENT CAUSES | | (B) CVA | | 10 DAYS | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) HYPERTENSION | | YEARS | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22. I certify that (I) (this hospital) attended the deceased from 7 OCTOBER 1967 to 21 OCTOBER 1967, that (I) (we) last saw the deceased alive on 20 OCTOBER 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | YES | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| William A. Dear Jr. | | 22 Oct. 67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| William A. Dear Jr. | | Mercy Hospital, Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | Oct. 25, 67 | | Glen Haven Mem'l Park | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| Oct 24 1967 | | Robert E. Singleton | | R.V. Singleton | |
| | | | | Glen Burnie, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|--|---|--|--|
| 67 10104 | | CERTIFICATE OF DEATH | | 67 10104 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Alexander A. Kiesel | | 10-19-67 7:45 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| 43 South Baltimore General Hosp. | | Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore #21225 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 3838 6th. St. | | 25-04 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| M | White | Divorced | 5-11-1897 | 70 | Office Supervisor |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| Ret. Office Supervisor | | U.S.I. Co. | Penna | USA | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Henry Kiesel | | | Matilda Broch | | |
| 15. Was Deceased Ever in U.S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT | | |
| Yes X WW-1 | | 215-03-2630 | Mr. Walter Kiesel (brother) | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 593X I | | (A) DUE TO | | Acute uremia | |
| ANTECEDENT CAUSES | | (B) DUE TO | | Chronic renal failure | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-15 1967 to 10-19 1967, that (I) (we) last saw the deceased alive on 10-19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| John Albert Bigbee M.D. | | | | 10-20-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| John Albert Bigbee | | 1213 Light St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | Oct. 23, 1967 | | Glen Haven Memorial Pk. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| OCT 24 1967 | | Robert E. Taylor | | E.B. Fleming | |
| | | | | Singleton Funeral Home | |
| | | | | Glen Burnie, Maryland | |

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China's early history

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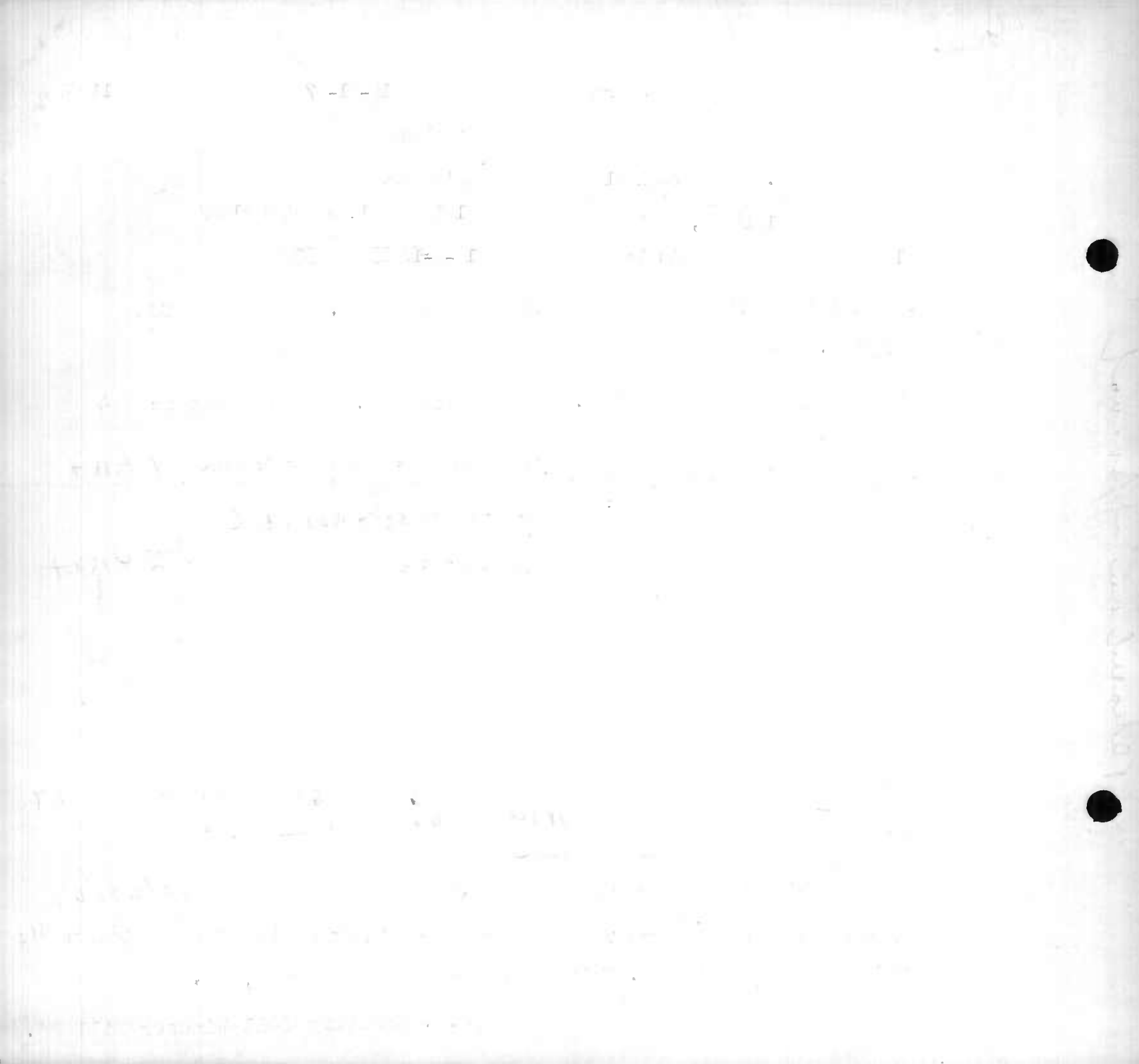
1000

1000

13-511
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released and approved
FUNERAL DIRECTOR: IMPORTANT

| | | | | | |
|---|------------------|--|--|--|--|
| BIRTH NO.
67 10105 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10105 | |
| 1. NAME OF DECEASED
(Type or Print)
George David Bambrey | | | 2. DATE AND HOUR OF DEATH
10-21-67 11:50 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION
40 St. Agnes Hospital
Caton and Wilkens Avenue
Baltimore, Maryland #29 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1916 Woodlawn Drive 21207 | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
12-8-1913 | 9. AGE (In years lost birthday)
53 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
S.S Administration US Government | | 10B. KIND OF BUSINESS OR INDUSTRY
Everson Pa. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
George A. Bambrey | | | 14. MOTHER'S MAIDEN NAME
Christina Byrne | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) WW2 | | 16. SOCIAL SECURITY NO.
12/11/42 7/7/43 160.12/5081 | | 17. INFORMANT
Joseph V. Bambrey Same as # 4 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
42011
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
(A) MYOCARDIAL INFARCTION
(B) ARTERIOSCLEROTIC CU
(C) Disease
INTERVAL BETWEEN ONSET AND DEATH
1 hr +
2 yrs + | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6 1960 to 10/21 1967, that (I) (we) last saw the deceased alive on 11/4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Phyllis E. Poach | | | | 23B. DATE SIGNED
10/23/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Thomas E. Poach | | | | 23D. ADDRESS
5530 BARTON VILLAGE BLVD BALTIMORE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/25/67 | | 24C. NAME OF CEMETERY OR CREMATORY
St. John Cemetery | |
| 24D. LOCATION
Scottdale, Pa. | | 24E. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 24F. NAME OF REGISTRAR
Robert E. Fink | |
| 24G. DATE REC'D BY HEALTH DEPT. | | 24H. NAME OF REGISTRAR | | 24I. FUNERAL DIRECTOR
J.T. Stansbury | |
| 24J. ADDRESS
6411 Windsor Mill Rd. | | 24K. ADDRESS | | 24L. ADDRESS | |



1
B-300

67 10106

BALTIMORE CITY HEALTH DEPARTMENT

67 10106

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HOWARD

-T- P.

BOYD

2. DATE AND HOUR PRONOUNCED DEAD

October 22, 1967

2:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
10-25-67

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4313 Hamilton Avenue

21206

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

2-24-1907

9. AGE (In years
lost birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Special Police

10B. KIND OF BUSINESS OR INDUSTRY

General Service Adm.

11. BIRTHPLACE (State or foreign country)

Perryville, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Walter P. Boyd

14. MOTHER'S MAIDEN NAME

Carrie Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W W 11

16. SOCIAL
SECURITY NO.

219-16-9462

17. INFORMANT

ADDRESS

Madelin Boyd 4313 Hamilton Avenue 21206

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK

NOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/22/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10-25-1967

23C. NAME of CEMETERY or CREMATORY

Baltimore Nat'l Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Co.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 24 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Lassahn Funeral Home 7401 Belair

ADDRESS

(34) Road

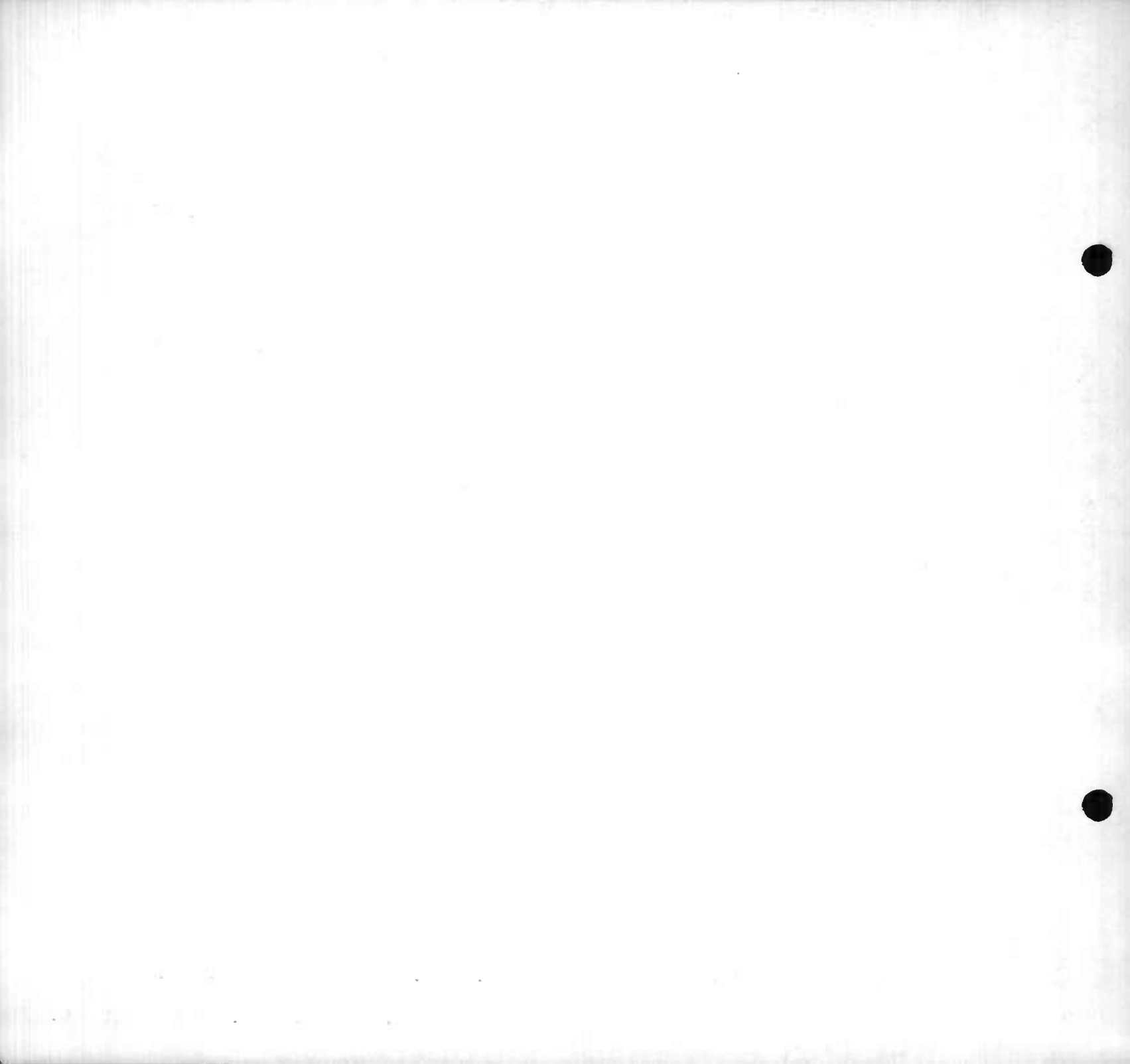
WILEY FARM
WILEY FORD

WILEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10107 | | | | BALTIMORE CITY DEPARTMENT | | Registered No. 67 10107 | |
|--|--|--|--|--|--|-------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) MARTHA BOTHS | | | |
| 2. DATE AND HOUR OF DEATH OCT. 22, 1967 2:50 A.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSP. | | | | A. STATE MD. | | | |
| | | | | B. COUNTY BALTIMORE 21223 | | | |
| 5. SEX F | | | | 6. RACE W | | | |
| 7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | | 8. DATE OF BIRTH 10/12/12 | | | |
| 9. AGE (In years lost birthday) 55 | | | | 10. AGE (In years lost birthday) 55 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) NEW YORK | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME DWANE SLOCOM | | | | 14. MOTHER'S MAIDEN NAME MARTHA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. NONE | | | |
| 17. INFORMANT HOSPITAL CHART | | | | ADDRESS | | | |
| 18. 260X I | | | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) Coronary Vascular accident and Bronchopneumonia | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | (B) Atherosclerosis | | | |
| ANTECEDENT CAUSES | | | | (C) Diabetes Mellitus | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Upper G.I. Bleeding - when? | | | |
| 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20A. AUTOPSY (Yes or No) Yes | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/19 19 67 to 10/22 19 67 , that (I) (we) last saw the deceased alive on 10/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Robert E. Denny M.D. | | | | 23B. DATE SIGNED 10/22/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS Franklin Square Hospital M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 10/24/67 | | | |
| 24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Pk. | | | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 24 1967 | | | | 25B. NAME OF REGISTRAR Robert E. Denny | | | |
| 25C. FUNERAL DIRECTOR JOHN F. DENNY, INC. | | | | ADDRESS 715 Light St. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 67 10108 | |
|---|------------------------|---|--|---|--|
| BIRTH NO. 67 10108 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Joseph Stanley Anikis | | 2. DATE AND HOUR OF DEATH
Oct. 22, 1967 8:50 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

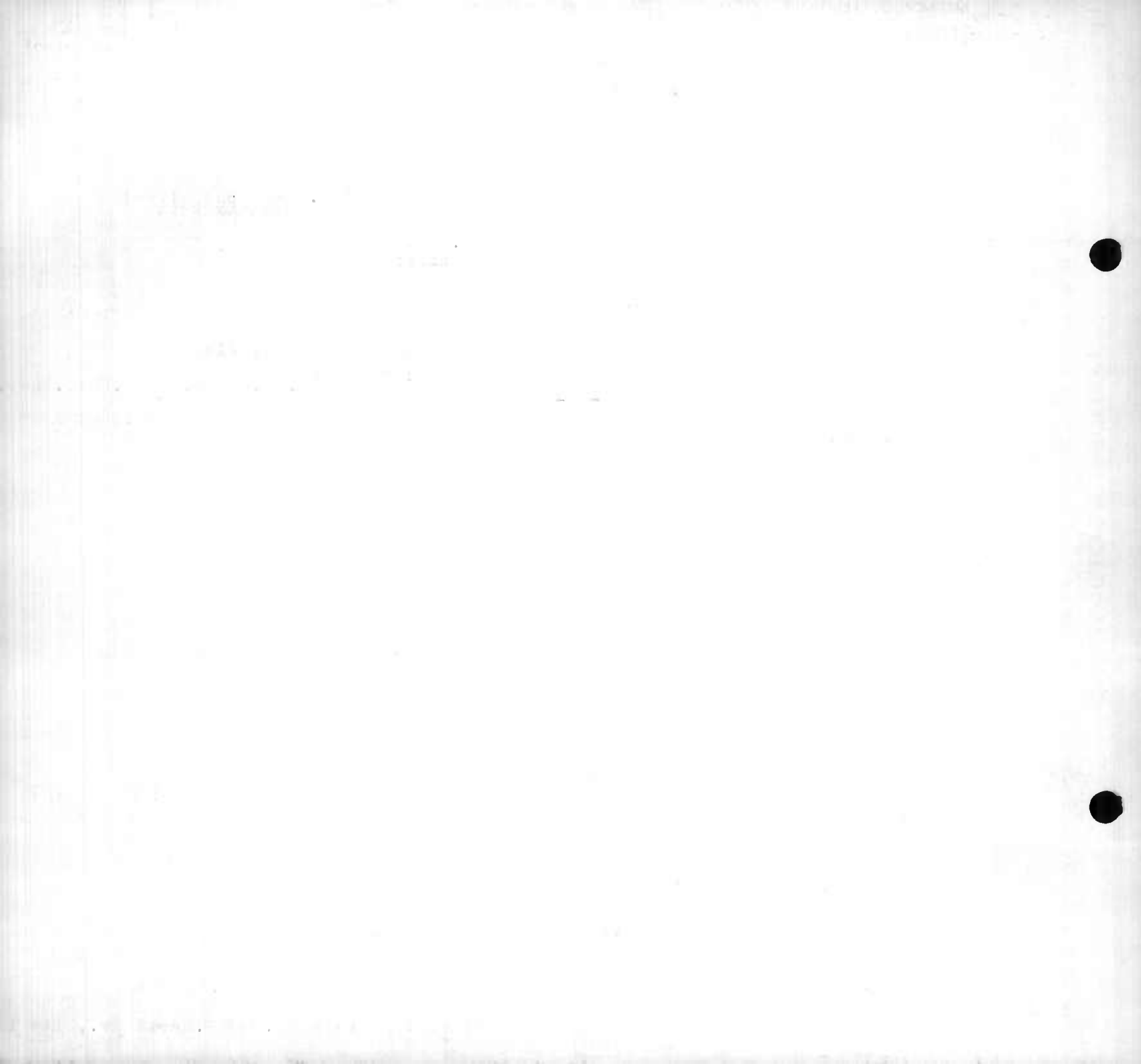
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

00 4822 Palmer Ave. | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
4822 Palmer Ave. 27-17 | | | |
| 5. SEX
Male | 6. RACE
Cau. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Aug. 21, 1903 | 9. AGE (In years last birthday)
64 | If Under 1 Yr. Months Days Hours Min.
If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY
Life Insurance | | 11. BIRTHPLACE (State or foreign country)
Chicago, Illinois | |
| 13. FATHER'S NAME
John Anikis | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-03-1286 | | 17. INFORMANT ADDRESS
Mrs. Rose Anikis, 4822 Palmer Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
154X I
Carcinoma of Rectum
CAUSE OF DEATH
(A) DUE TO
none
(B) DUE TO
none
(C) DUE TO
none
INTERVAL BETWEEN ONSET AND DEATH
1 year | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II
none | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 29 19 66 to Oct 22 19 67 , that (I) (we) lost saw the deceased alive on Oct 22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Manuel Levin | | | | 23B. DATE SIGNED
10/23/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Manuel Levin, M.D. | | 23D. ADDRESS
M.D. 4818 Reisterstown Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/23/67 | | 24C. NAME of CEMETERY or CREMATORY
Druid Ridge Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Pikesville, Balto. Co. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
Robert E. Taylor 4611 Park Heights Ave. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10109 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10109 | |
|---|---------------------|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) DINWIDDIE VIRGINIA ELLINGER | | | | 2. DATE AND HOUR OF DEATH
10-21-1967 4:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
49 NORTH CHARLES GEN. HOSP. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
101 W. Monument Street | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH
Dec. 12, 1882 | | 9. AGE (in years last birthday)
84 | 10. If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
Secretarial | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
SAMUEL ELLINGER | | | | 14. MOTHER'S MAIDEN NAME
Mary Dinwiddie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-54-2152 | | 17. INFORMANT: Friend - Mrs. E. R. Ford ADDRESS 909 W. Univ. Pkwy. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
CVA
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH
(A) DUE TO
ASCVD
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
52 days
25 years | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 8-30 19 67 to 10-21 19 67 , that (1) (we) last saw the deceased alive on 10-21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Harvey Feuerman | | | | 23B. DATE SIGNED
10-21-1967 | | 23C. PHYSICIAN'S NAME (Type)
HARVEY FEUERMAN | |
| 23D. ADDRESS
6210 Park Heights Ave. BALTIMORE 15, Md. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/24/67 | | 24C. NAME OF CEMETERY or CREMATORY
Woodlawn, | | 24D. LOCATION (City, town, or county) (State)
Woodlawn, Maryland | |
| 25A. DATE RECEIVED AT HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairburn | | 25C. FUNERAL DIRECTOR ADDRESS
Stewart & Mowen Co. 108 W. North Av., City 1 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|------------------------------------|--|--|
| BIRTH NO. 67 10110 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10110 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) ROBERT ROY LOWE | | 2. DATE AND HOUR OF DEATH
10/20/67 9:25P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MD. B. COUNTY BALTO. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
FRANKLIN SQUARE HOSP. | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location)
72 Torque way | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
1/26/01 | 9. AGE (In years lost birthday)
66 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
TENN. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
JOHN C. LOWE | | 14. MOTHER'S MAIDEN NAME
ELIZABETH APPERSON | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
ARMY | | 16. SOCIAL SECURITY NO.
411058063 | | 17. INFORMANT
Records | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)
ACUTE MYOCARDIAL INFARCT
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ATHEROSCLEROSIS | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/20 1967 to 10/20 1967 , that (I) (we) last saw the deceased alive on 10/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Hector L. Feliciano | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
HECTOR L. FELICIANO | | 23D. ADDRESS
FRANKLIN SQ. H. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
REMOVAL | | 24B. DATE
10/22/67 | | 24C. NAME OF CEMETERY OR CREMATORY
BAKERS FORGE CEM | |
| 24D. LOCATION (City, town, or county) (State)
LA FOLLETTE TENN | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairman | |
| 25C. FUNERAL DIRECTOR
J.G. CONNELLY SONS | | 25D. ADDRESS
300 MACE | | | |

FRANKLIN SQUARE HOSP
11/2/51
75 Temple way
FALIC

JOHN C. CLINE
HEAD
ELIZABETH APPERSON
TENN.
W.K.

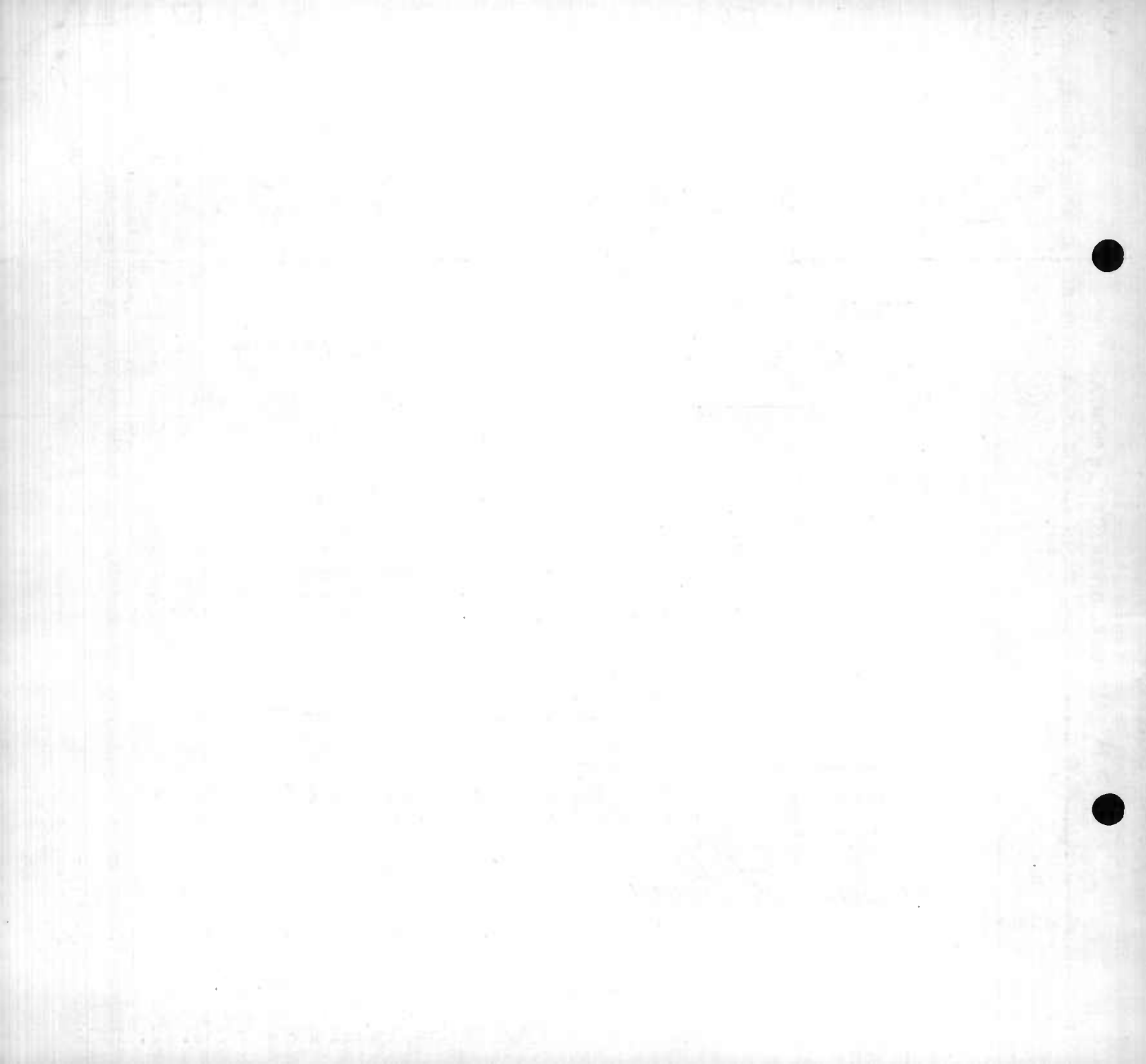
NEC

FRANKLIN SQUARE HOSP
11/2/51
75 Temple way
FALIC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|---------------------|---|---|--|--|
| 67 10111 | | CERTIFICATE OF DEATH | | 67 10111 | |
| 1. NAME OF DECEASED
(Type or Print) Edwin F. Duncan | | | 2. DATE AND HOUR OF DEATH
10-22-67 1:40 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Maryland General Hospital
(If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 27-09 | | |
| | | | D. STREET ADDRESS (If rural, give location)
1513 Pontridge Rd | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH
11/13/08 | 9. AGE (In years last birthday)
59 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Ohio | |
| 13. FATHER'S NAME
Dr. W. L. Duncan | | | 14. MOTHER'S MAIDEN NAME
Ida B. Ulbray | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-03-0640 | | 17. INFORMANT
Mary T. Duncan (Wife) Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
581.01 Pulmonary edema
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Potential cirrhosis, | | | INTERVAL BETWEEN ONSET AND DEATH
7 | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Arteriosclerotic heart disease | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-31-67 to 10-22-67 , that (I) (we) last saw the deceased alive on 10-22-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
William L. Boddie M.D. | | | | 23B. DATE SIGNED
10-22-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. Maryland General Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY
Friends Burial Ground | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
R. L. E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 21212 | |

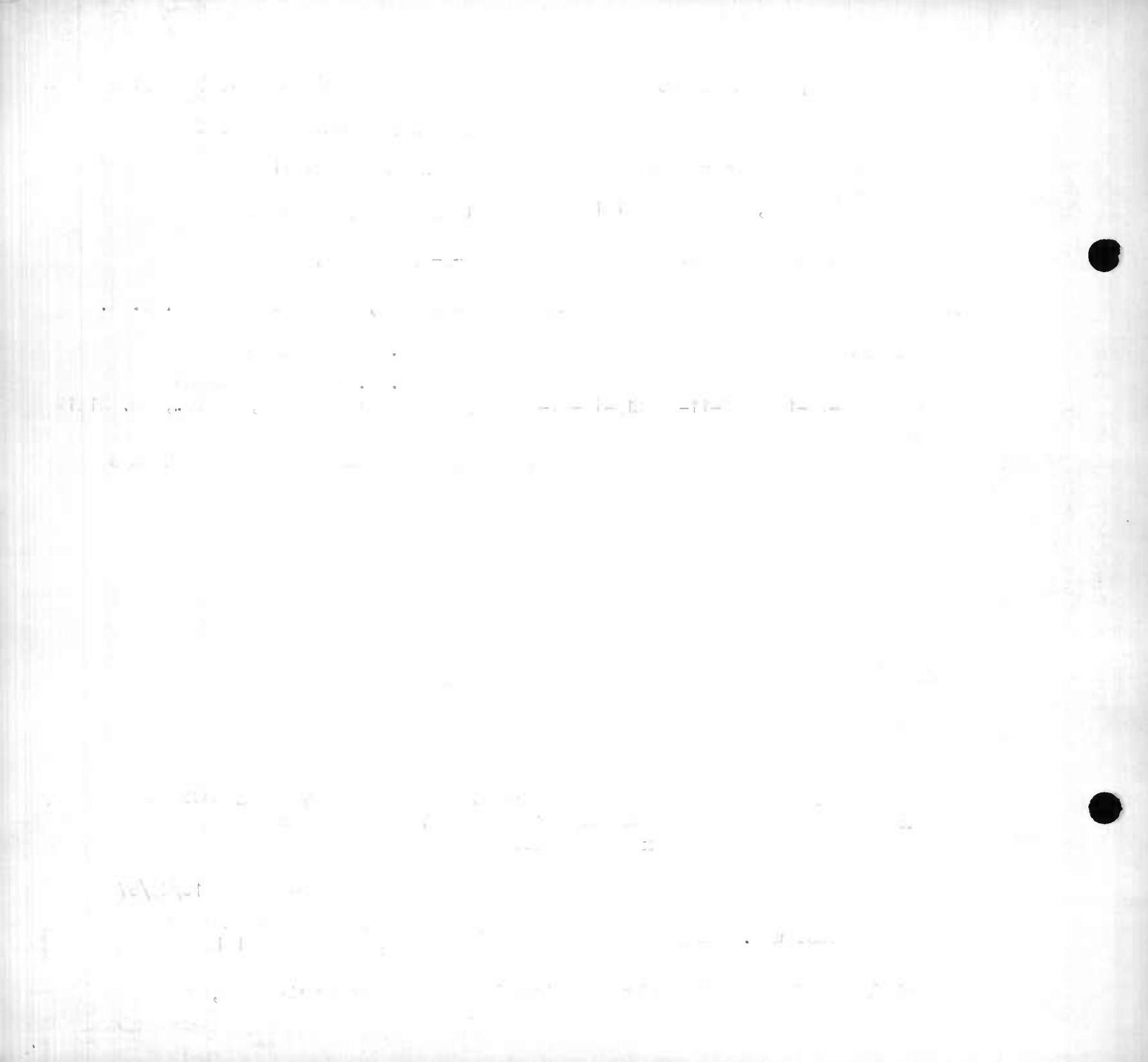


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

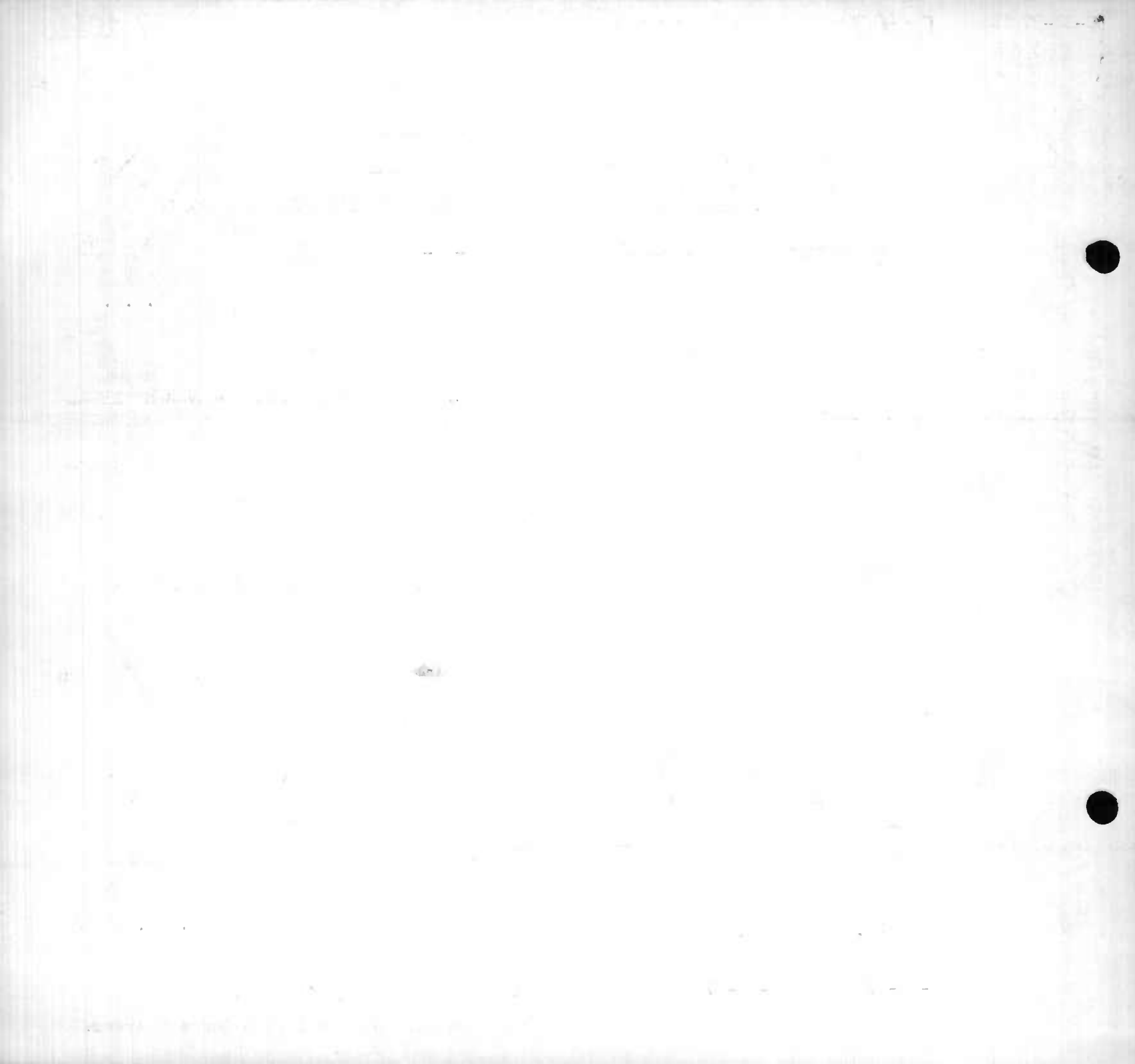
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 10112</u> | |
|---|-----------------------------|---|-----------------------------------|--|---|
| BIRTH NO. <u>67 10112</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>22 OCTOBER 1967</u> <u>7:00</u> <u>A M.</u> | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>ISLAUB, Frank Albert</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> CITY <u>CITY</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>27</u> <u>VETERANS ADMINISTRATION HOSPITAL</u>
<u>3900 LOCH RAVEN BOULEVARD</u>
<u>BALTIMORE, MARYLAND 21218</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> <u>21211</u> <u>13-08</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>1204 WEST 36TH STREET</u> | | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>CAUCASION</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>DIVORCED</u> | 8. DATE OF BIRTH
<u>9-5-97</u> | 9. AGE (In years
last birthday)
<u>70</u> | If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>LABORER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>RUBBER INDUSTRY</u> | | 11. BIRTHPLACE (State or foreign country)
<u>ST JOSEPH, MISSOURI</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | 13. FATHER'S NAME
<u>ALBERT ISLAUB</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>ROSE M. MISENHEIMER</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>YES</u> <u>4-12-16</u> <u>TO 4-11-20</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>213-18-01-04</u> | | 17. INFORMANT <u>V. A. HOS PITAL RECORDS</u> ADDRESS
<u>3900 LOCH RAVEN BLVD, BALTO., MD. 21218</u> | | | |
| 18. <u>420.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>CORONARY THROMBOSIS</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>2 Days</u> | | (A) DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Ooy) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>20 OCTOBER 19 67</u> to <u>22 OCTOBER 19 67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>22 OCTOBER 19 67</u> and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <u>not</u> view the body after death. | | | | | |
| 23A. SIGNATURE <u>V. B. Mulay</u>
M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
<u>10/22/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Vissnu B. Mulay</u> | | | | 23D. ADDRESS
<u>3900 LOCH RAVEN BOULEVARD</u>
<u>BALTIMORE, MARYLAND 21218</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>10/25/67</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Balto National</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Frederick Rd, Md</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 24 1967</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Paul E. Fisher</u> | | 25C. FUNERAL DIRECTOR
<u>Austin C. Donovan</u> ADDRESS
<u>3818 Roland Ave</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|---|--|---|
| F-432 67 10113 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10113 | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) DOLORES E. FIELDS | | 2. DATE AND HOUR OF DEATH
20 October 1967 5:15 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 4940 EASTERN AVENUE
BALTIMORE, MARYLAND | | A. STATE MARYLAND
B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
4822 HAMILTON AVENUE 21206 | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
MARRIED | 8. DATE OF BIRTH
5-15-16 | 9. AGE (In years lost birthday)
51 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
IOWA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
RALPH DOUGLAS | | | 14. MOTHER'S MAIDEN NAME
HAZEL LISK | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
BCN: RECORDS 4940 EASTERN AVENUE 21224 | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DIABETES MELLITUS
DUE TO
(B) UREMIA
DUE TO
(C) ? MYXEDEMA
Kimmelsteil-Wilson Disease | | INTERVAL BETWEEN ONSET AND DEATH
14 years
months | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 20 SEPTEMBER 1967 to 20 OCTOBER 1967 , that the (we) last saw the deceased alive on 20 OCTOBER 1967 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Michael R. McMillan M.D. | | | | 23B. DATE SIGNED
20 October 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. MICHAEL R. MC MILLIAM M.D. | | | | 23D. ADDRESS
4940 EASTERN AVENUE BALTO. MD. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Interment | | 24B. DATE
IO-24-67 | | 24C. NAME OF CEMETERY or CREMATORY
Gardens of Faith | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS
Walter Dabrowski 1005 Dundalk Avenue | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------------------|---|---|---|--|
| BIRTH NO.
67 10114 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10114 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) <i>Elena Plack</i> | | | 2. DATE AND HOUR OF DEATH
<i>10-22-67</i> <i>8:00 P. M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
<i>43</i>
<i>South Baltimore General Hospital</i>
(If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i>
D. STREET ADDRESS (If rural, give location)
<i>1621 Olive St.</i> | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>7 12 1907</i> | 9. AGE (In years
last birthday)
<i>60</i> | If Under 1 Yr. Months Days Hours Min.
If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>At Home</i> | 11. BIRTHPLACE (State or foreign country)
<i>Balto. Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U S A</i> |
| 13. FATHER'S NAME
<i>George Von Cullin</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Mary Schuck</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
<i>Mr. Emerald Cole 282 Hillside Terrace</i> | | |
| 18. <i>420.11</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) <i>Myocardial infarction (probable)</i>
DUE TO
(B) <i>Atherosclerotic cardiovascular disease with secondary congestive heart failure</i>
DUE TO
(C)
INTERVAL BETWEEN ONSET AND DEATH
<i>< 1 hour probable</i>
<i>Several years</i> | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-20-1967</i> to <i>10-22-1967</i> , that (I) (we) last saw the deceased alive on <i>10-22-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>John Albert Bigbee</i> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS
M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | 24B. DATE
<i>10 26 67</i> | 24C. NAME of CEMETERY or CREMATORY
<i>Cedar Hill</i> | 24D. LOCATION (City, town, or county) (State)
<i>Brooklyn, A. A. Co. Md.</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 24 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fisher</i> | 25C. FUNERAL DIRECTOR
<i>Mc Gully</i> | | ADDRESS
<i>130 E. Fort Ave</i> |

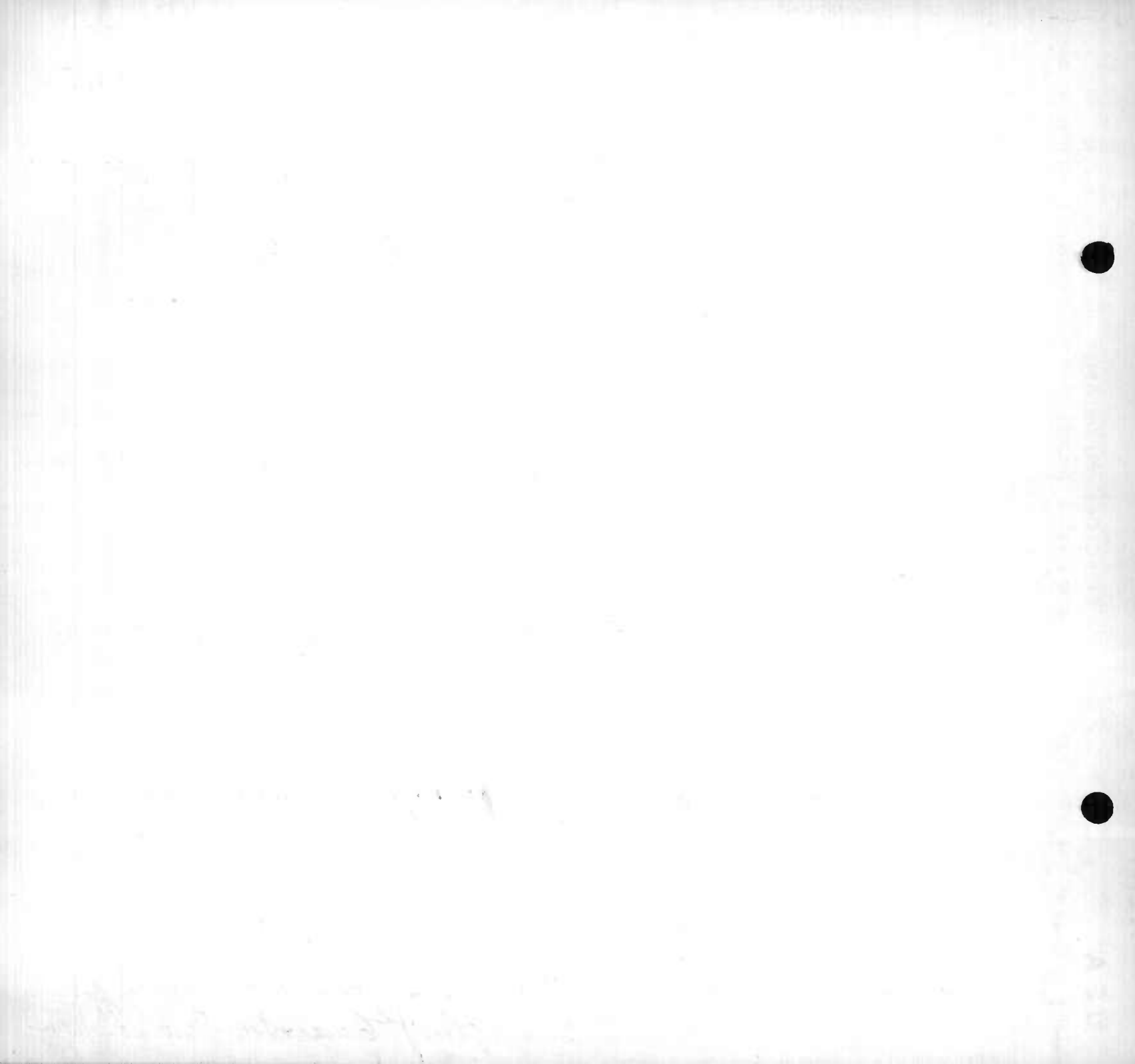
Handwritten text, possibly a date or reference number.

Handwritten text, possibly a name or title.

Handwritten text, possibly a signature or name.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|--|--|--|---|--|
| 67 10115 | | 67 10115 | | 67 10115 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | JAMES M. DOWD | | 2. DATE AND HOUR OF DEATH
OCTOBER 21 8:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31
BALTIMORE, CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | A. STATE
MARYLAND | | B. COUNTY | |
| 5. SEX
MALE | | 6. RACE
WHITE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | |
| 8. DATE OF BIRTH
8-21-95 | | 9. AGE (In years lost birth)
72 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Boiler Maker | | 10B. KIND OF BUSINESS OR INDUSTRY
B+O. R.L. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
PATRICK Dowd | | 14. MOTHER'S MAIDEN NAME
DUGGAN ANNIE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
BCH: BALTIMORE, CITY HOSPITALS
4940 EASTERN AVENUE 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
537.2 I
Chronic Obstructive Pulmon. Dis. | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
unknown | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | II
Other Significant Conditions Contributing to the Death but not related to the disease or condition causing it.
fever of Undetermined Origin | | 4 wks. | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPRDX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (1) (this hospital) attended the deceased from 9/21/67 to 10/21/67
that (1) (we) last saw the deceased alive on 10/21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Raymond J. LaSore | | 23B. DATE SIGNED
10/21/67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
RAYMOND J. LA SURE | | 23D. ADDRESS
4940 EASTERN AVENUE BALTIMORE MARYLAND 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/25/67 | | 24C. NAME OF CEMETERY or CREMATORY
new Cathedral Can. | |
| 24D. LOCATION (City, town, or county) (State)
4300 Old Frederick Rd. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
Robert S. Feltner | |
| 25C. FUNERAL DIRECTOR
John J. Gorman & Son Inc. | | 25D. ADDRESS
23rd St. | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10116

BIRTH NO.

M.E. CASE NO.

I. NAME OF DECEASED

(Type or Print)

ERNEST WINFIELD MYERS

2. DATE AND HOUR PRONOUNCED DEAD

October 22, 1967 3:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY BALTO. CO.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore TOWSON 53-00

D. STREET ADDRESS (If rural, give location)

126 E. Chesapeake Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

2/12/39

9. AGE (In years last birthday)

28

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CHARACTER Trucking Firm

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ernest L. Myers

14. MOTHER'S MAIDEN NAME

Bernice Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

214-36-9307 Fannie Myers - 126 E. Chesapeake Ave

17. INFORMANT

ADDRESS

TOWSON

E 823.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Eads Road - Baltimore County 53-00

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) 10/22/67 2:45 A.

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR? (Driver) Failed to negotiate sharp curve - struck a tree

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/22/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

10/26/67

23C. NAME OF CEMETERY or CREMATORY

Pleasant Rest

23D. LOCATION (City, town, or county) (State)

Towson, Balto. Co. Md.

24A. DATE REC'D BY HEALTH DEPT

OCT 24 1967

24B. NAME OF REGISTRAR

D. E. Toomey

24C. FUNERAL DIRECTOR

Wm. J. Chotman - 1701 W. E. Cullum St

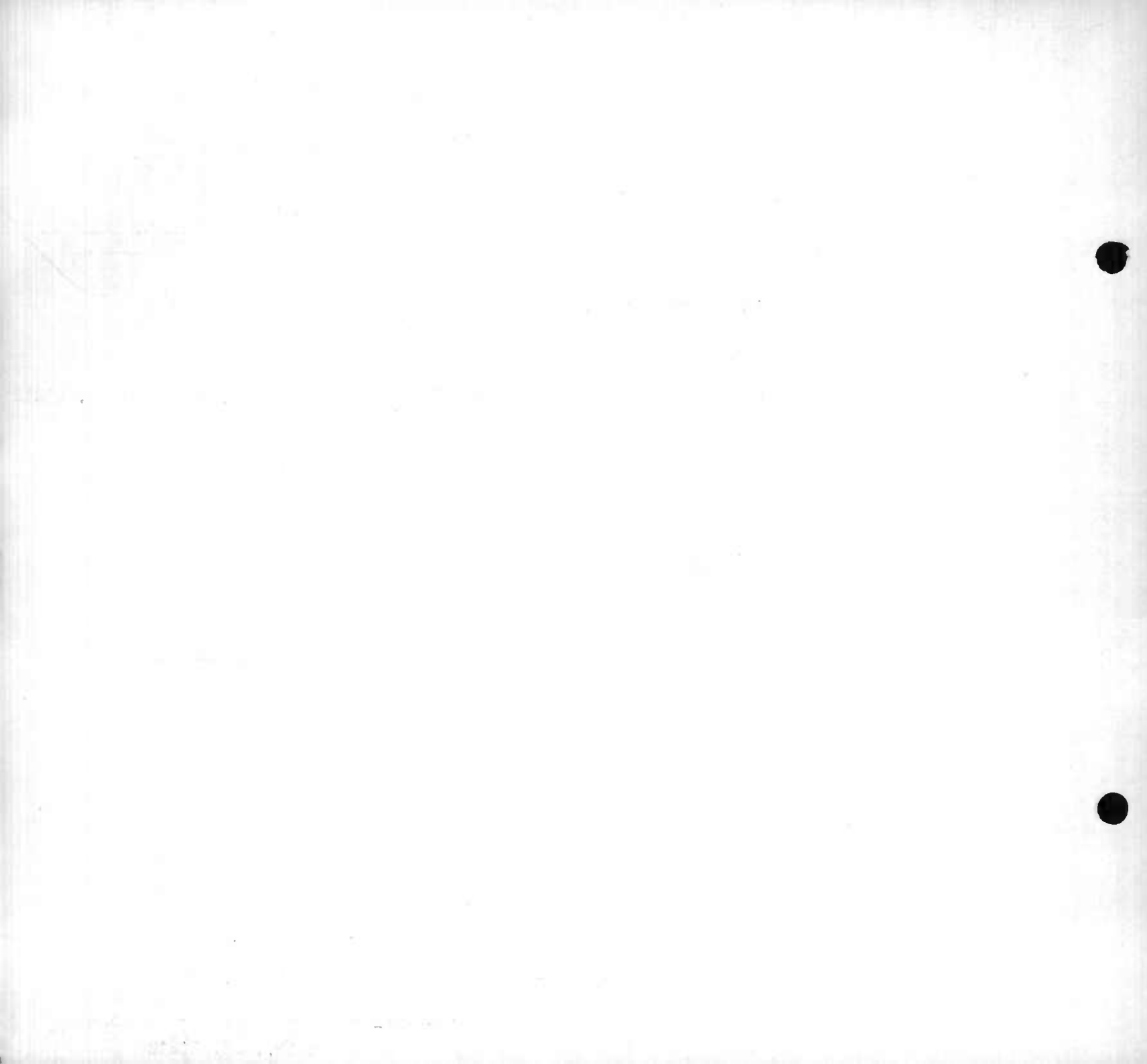
ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------|--|--------------------------|---|--|
| BIRTH NO. 67 10117 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10117 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Robert E. Kelley | | 2. DATE AND HOUR OF DEATH
10-22-67 7:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 8011 York Rd. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 7-22-89 | 9. AGE (In years last birthday) 78 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | 10B. KIND OF BUSINESS OR INDUSTRY Title Guarantee Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME William T. Kelley | | 14. MOTHER'S MAIDEN NAME Alice Ewing | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 212-16-4875 | | 17. INFORMANT Paul Nichols (Grandson) | | ADDRESS 207 Rodgers Forge Rd. #21212 | |
| 18. 332 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Cerebral Thrombosis DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William L. Boddie | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 10-22-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS Maryland General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 10/25/67 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral | |
| 24D. LOCATION Baltimore, Maryland | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. 10-22-67 | | 25B. NAME OF REGISTRAR Robert E. Kelley, M.D. | | 25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home | |
| 25D. ADDRESS 6500 York Road | | 25E. ADDRESS Balto., Md. 21212 | | | |

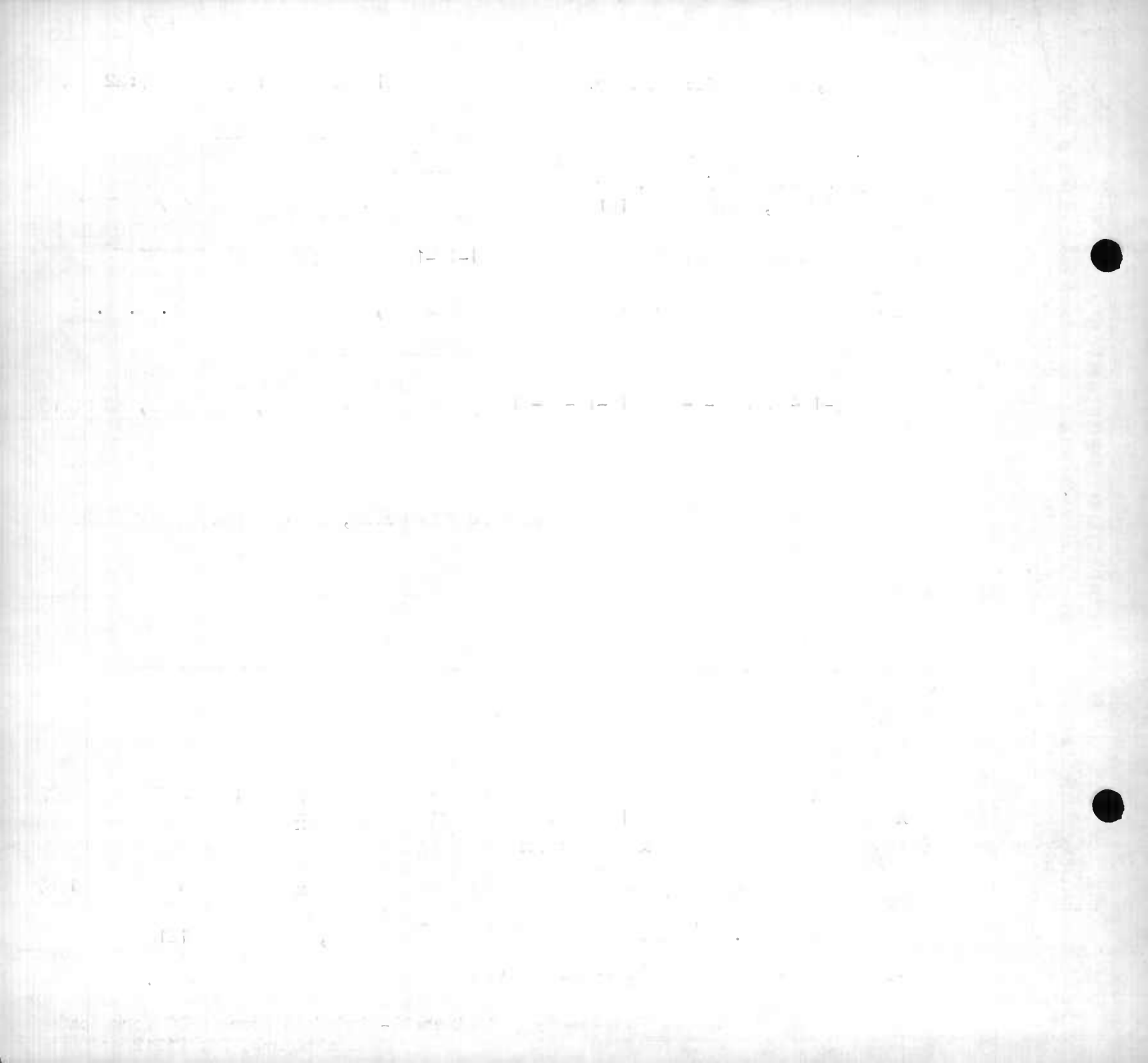


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|------------------------------|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10118 | |
| BIRTH NO. 67 10118 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) KANE, Thomas Michael, Jr. | | 2. DATE AND HOUR OF DEATH
21 OCTOBER 1967 7:22 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
VETERANS ADMINISTRATION HOSPITAL
3900 LOCH RAVEN BOULEVARD
BALTIMORE, MARYLAND 21218 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE CITY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2424 GREENMOUNT AVENUE | |
| 5. SEX
MALE | 6. RACE
CAUCASION | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
DIVORCED | 8. DATE OF BIRTH
1-19-17 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PAINTING | | 10B. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION | 9. AGE (In years lost birthday)
50 |
| 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
THOMAS KANE | | 14. MOTHER'S MAIDEN NAME
KATHERINE CHISHAM | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES 7-17-42 TO 2-2-43 | | 16. SOCIAL SECURITY NO.
219-18-40-01 | |
| 17. INFORMANT
HOSPITAL RECORDS | | ADDRESS
3900 LOCH RAVEN BLVD, BALTIMORE, MD 21218 | |
| 18. 502.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
RESPIRATORY FAILURE
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
CHRONIC BRONCHITIS, & EMPHYSEMA | | INTERVAL BETWEEN ONSET AND DEATH
TWO WEEKS
MANY YEARS | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2 OCTOBER 19 67 to 21 OCTOBER 19 67 , that no (we) last saw the deceased alive on 21 OCTOBER 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) not view the body after death. | | | |
| 23A. SIGNATURE
John L. Cameron, M.D. | | 23B. DATE SIGNED
21 OCTOBER 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
JOHN L. CAMERON | | 23D. ADDRESS
3900 LOCH RAVEN BOULEVARD
BALTIMORE, MARYLAND 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
10/24/67 | 24C. NAME of CEMETERY or CREMATORY
Baltimore National | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home | | ADDRESS
6500 York Road
Baltimore, Md. 21212 | |



1
G-645

67 10119

BALTIMORE CITY HEALTH DEPARTMENT

67 10119

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEROGE L. GARLAND

2. DATE AND HOUR PRONOUNCED DEAD

October 3, 1967

11:50 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

21 W. Preston St.

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

Male

White

62

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO Arteriosclerotic Cardiovascular
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
m. WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

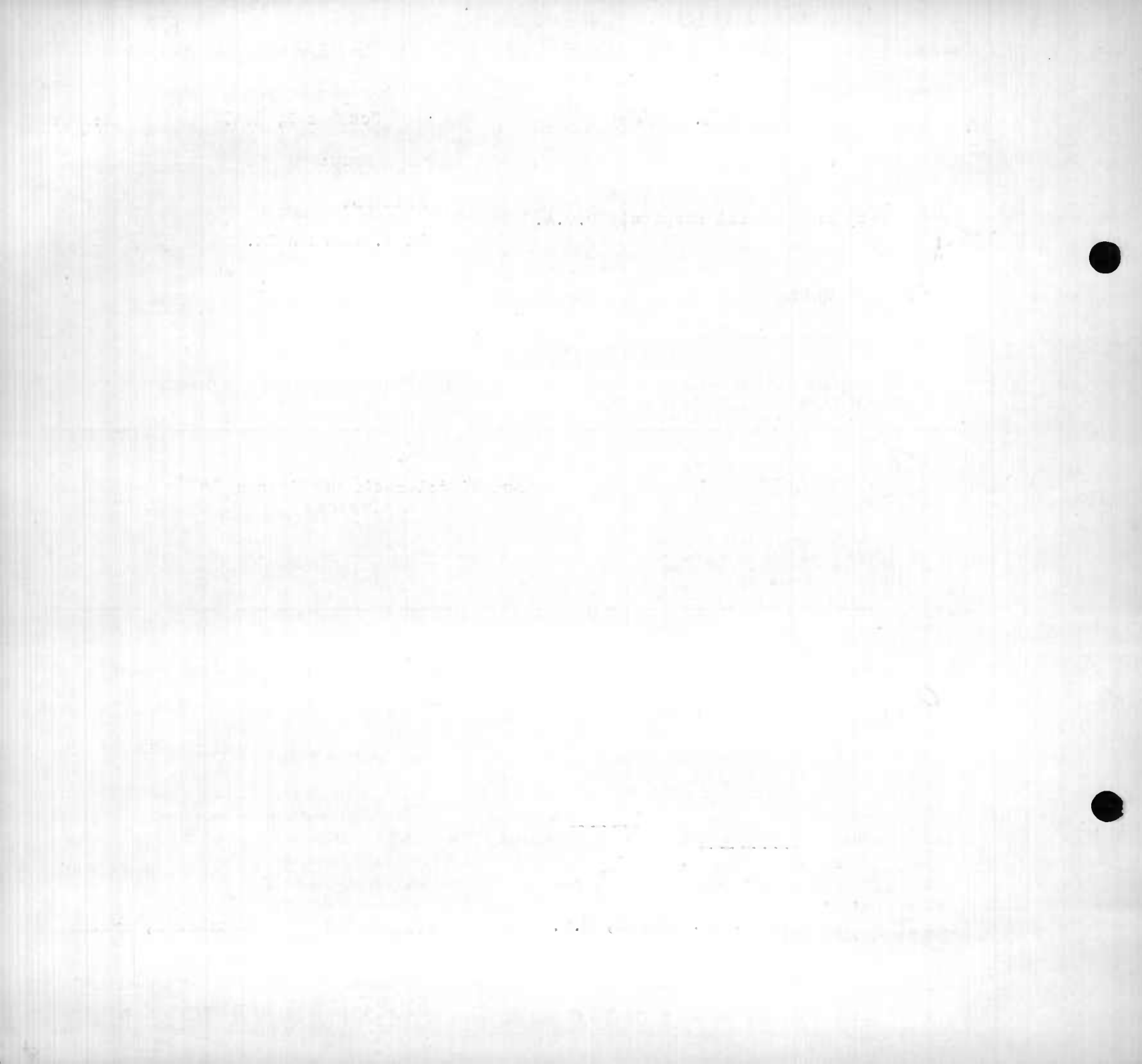
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

ANATOMY BOARD OF MARYLAND
October 3, 1967
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

TEACO KNIGHT

2. DATE AND HOUR PRONOUNCED DEAD

September 7, 1967

9:50 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

238 N. Pine Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

238 N. Pine Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday) 60If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Fatty metamorphosis of liver

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, lorn, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 8, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

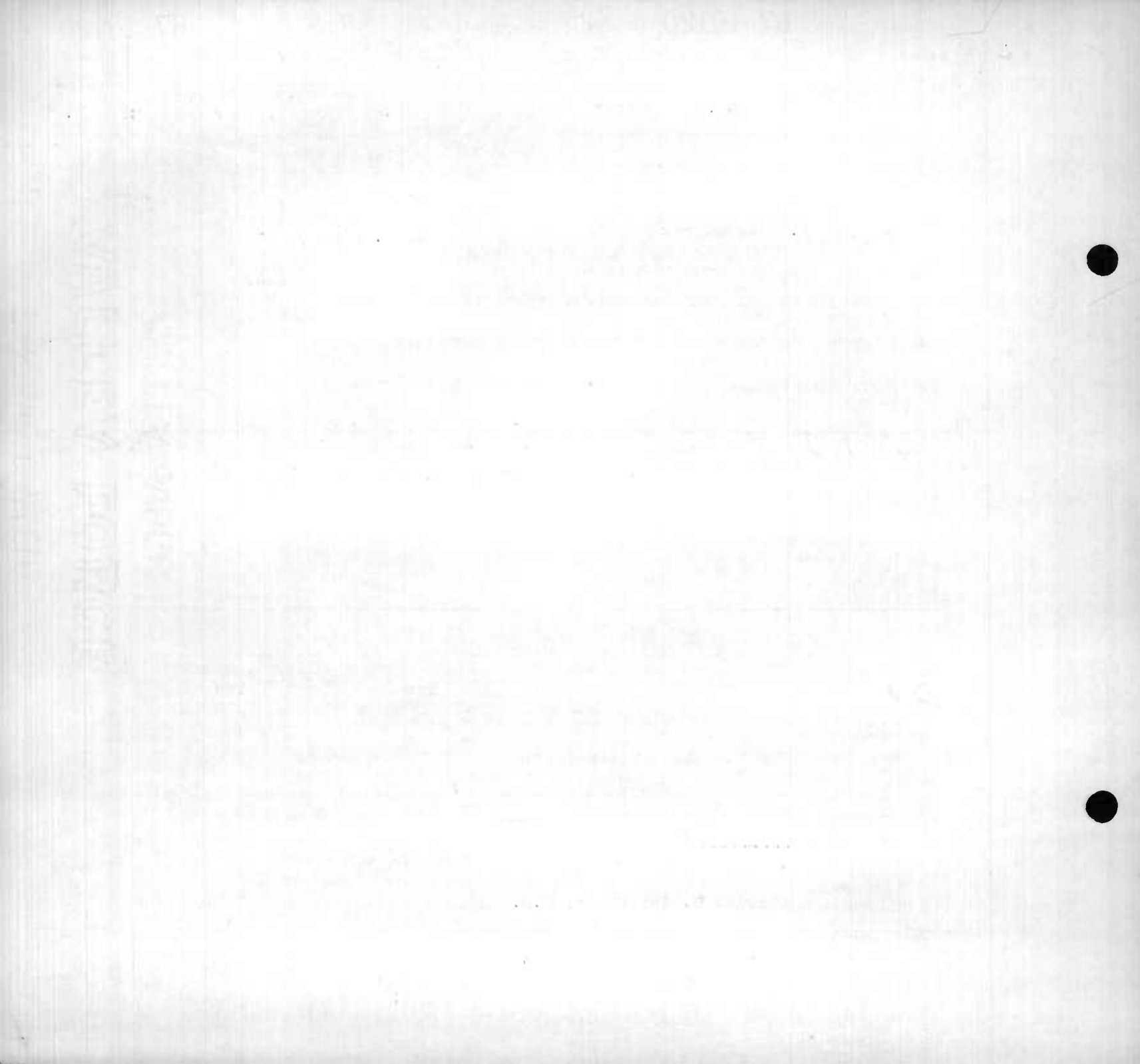
24C. FUNERAL DIRECTOR

ADDRESS

OCT 24 1967

Robert E. Fairbank

MORTUARY SERVICE - BCHD



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10121

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM ANDERSON

2. DATE AND HOUR PRONOUNCED DEAD

September 30, 1967

1:35 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF (If not in hospital or institution, give street
HOSPITAL OR ADDRESS OR LOCATION)
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1613 Riggs Ave.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (in years
last birthday)

47?

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

10-16-67

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D. BY HEALTH DEPT.

24B. NAME OF REGISTRAR

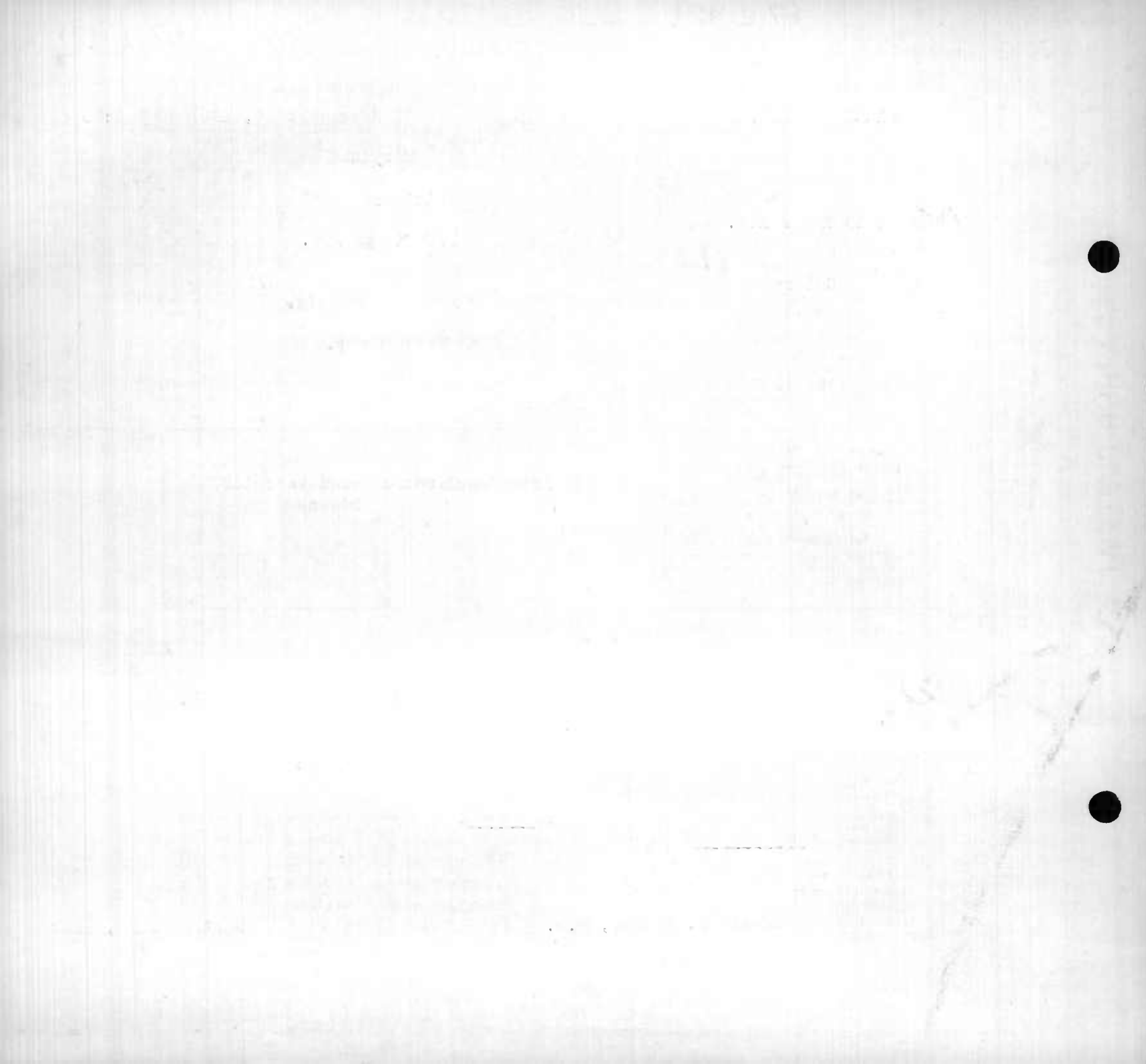
24C. FUNERAL DIRECTOR

ADDRESS

OCT 24 1967

R. E. F. Wilson

MORTUARY SERVICE - BCHD



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10122 | |
|---|---------|--|------------------|--|------------------------------|
| BIRTH NO. | | 67 10122 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | George M. Still | | October 21, 1967 9:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | 5. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | Maryland Baltimore | |
| 00 | | 3712 Gwynn Oak Avenue | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | | | Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) | |
| | | | | 3712 Gwynn Oak Avenue | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| Male | White | Married | 6-30-1901 | 66 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Service Man | | | | Baltimore Co., Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| Charles M. Still | | Laura A. Bosley | | NO | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 216-14-8844 | | Mary E. Still-3712 Gwynn Oak Avenue | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Coronary occlusion | | 1 hour | |
| ANTECEDENT CAUSES | | (B) Arteriosclerotic cardio-vascular disease | | 10 years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Parkinson's Disease | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| D | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) Dr. [Signature] attended the deceased from January 1967 to October 1967, that (1) Dr. [Signature] last saw the deceased alive on October 15, 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (1) Dr. [Signature] (did) not view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Dr. [Signature] | | | | 10/23/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Millard T. Traband, Jr. | | | | 1811 N. Rolling Rd. Baltimore, Md. 21207 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 10-24-67 | | Pinegrove Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| OCT 24 1967 | | Robert E. Farber, M.D. | | Ellsworth Armacost-4600 Liberty Hgts. Ave. | |
| 24D. LOCATION (City, town, or county) | | 24E. STATE | | | |
| Parkton, Maryland | | | | | |

5

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

5/3/5

1
4-520

67 10123

BALTIMORE CITY HEALTH DEPARTMENT

67 10123

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GUNNIE LYONS JR.

2. DATE AND HOUR PRONOUNCED DEAD

October 20, 1967

8:35 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00

1518 N. Patterson Park

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1518 N. Patterson Park Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 29, 1929

9. AGE (In years
last birthday)

38

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Bugle Laundry

11. BIRTHPLACE (State or foreign country)

Edgecomb, North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Gunnie Lyons Sr.

14. MOTHER'S MAIDEN NAME

Edna Hope

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

239-48-9825

17. INFORMANT

ADDRESS

Annie Mae Whitaker 1518 N. Patterson Pk.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchial asthma
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 20, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Wed. 25, 1967 Carmel Cemetery

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Rocky Mount, N. Carolina

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 24 1967

Robert E. Fairbairn

Donald E. Glover 1701-03 N. Patt. Pk.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|-----------------------------|---|--|
| BIRTH NO.
67 10124 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No.
67 10124 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print)
LUTHER E. GERWIG | | 2. DATE AND HOUR OF DEATH
10/23/67 12 45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
MARYLAND GENERAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location)
4004 VILLANOVA RD | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | B. DATE OF BIRTH
5-14-91 | 9. AGE (In years last birthday)
76 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Builder-Ret. | | 10B. KIND OF BUSINESS OR INDUSTRY
Building | | 11. BIRTHPLACE (State or foreign country)
Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
US | | 13. FATHER'S NAME
CHARLES GERWIG | | 14. MOTHER'S MAIDEN NAME
ELIZABETH TROILING | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
216-32-7336 | | 17. INFORMANT
John E. Gerwig - 3713 Sylvan Drive - Same.
Wife - Lottie Gerwig | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO
CARCINOMA of Rectum with post-operative effects
(B) DUE TO
Cardiac Failure due to above
(C) | | INTERVAL BETWEEN ONSET AND DEATH
8-10 weeks
5 weeks | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
9/12/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
CA 1 Rectum | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-1-19 67 to 10-23-19 67, that (I) (we) last saw the deceased alive on 10-23-19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Frank J. Zorick | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10-23-67 | |
| 23C. PHYSICIAN'S NAME (Type)
FRANK J. ZORICK | | 23D. ADDRESS
Md. General Hosp Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-26-67 | | 24C. NAME OF CEMETERY or CREMATORY
Woodlawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR
W. E. F. F. F. | | 25C. FUNERAL DIRECTOR
Ellsworth Armacost-4600 Liberty Hgts. Ave | | | |

MARSHALL GENERAL
 HOSPITAL
 H. W. MARSHALL
 Bldg. - 2nd. Bldg.
 CHURCH GROUND
 ELIZABETH GROUND
 W. J. GROUND

2-11-21
 2-11-21
 2-11-21

10-23-21

10-23-21

FRANK J. ZORICK
 10-23-21
 10-23-21
 10-23-21

5-530

67 10125 BALTIMORE CITY HEALTH DEPARTMENT

67 10125

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN SCHMITT

2. DATE AND HOUR PRONOUNCED DEAD

September 28, 1967 12:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

306 North Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (in years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

| 18. CAUSE OF DEATH | | INTERVAL BETWEEN
ONSET AND DEATH |
|--|--|-------------------------------------|
| I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.) | | |
| (A) <u>Arteriosclerotic heart disease</u>
DUE TO | | |
| (B) _____
DUE TO | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST. | | |
| (C) _____ | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | |

MEDICAL CERTIFICATION

| | | | |
|---|--|---|--|
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
Yes | 20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?
Yes |
| 21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | 21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR? | |
| 21D. TIME
OF INJURY
(APPROX.) | (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22.
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion
resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL
SIGNATURE <u>Charles S. Springate</u>
EXAMINER'S NAME (Type) | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED
September 28, 1967 | |

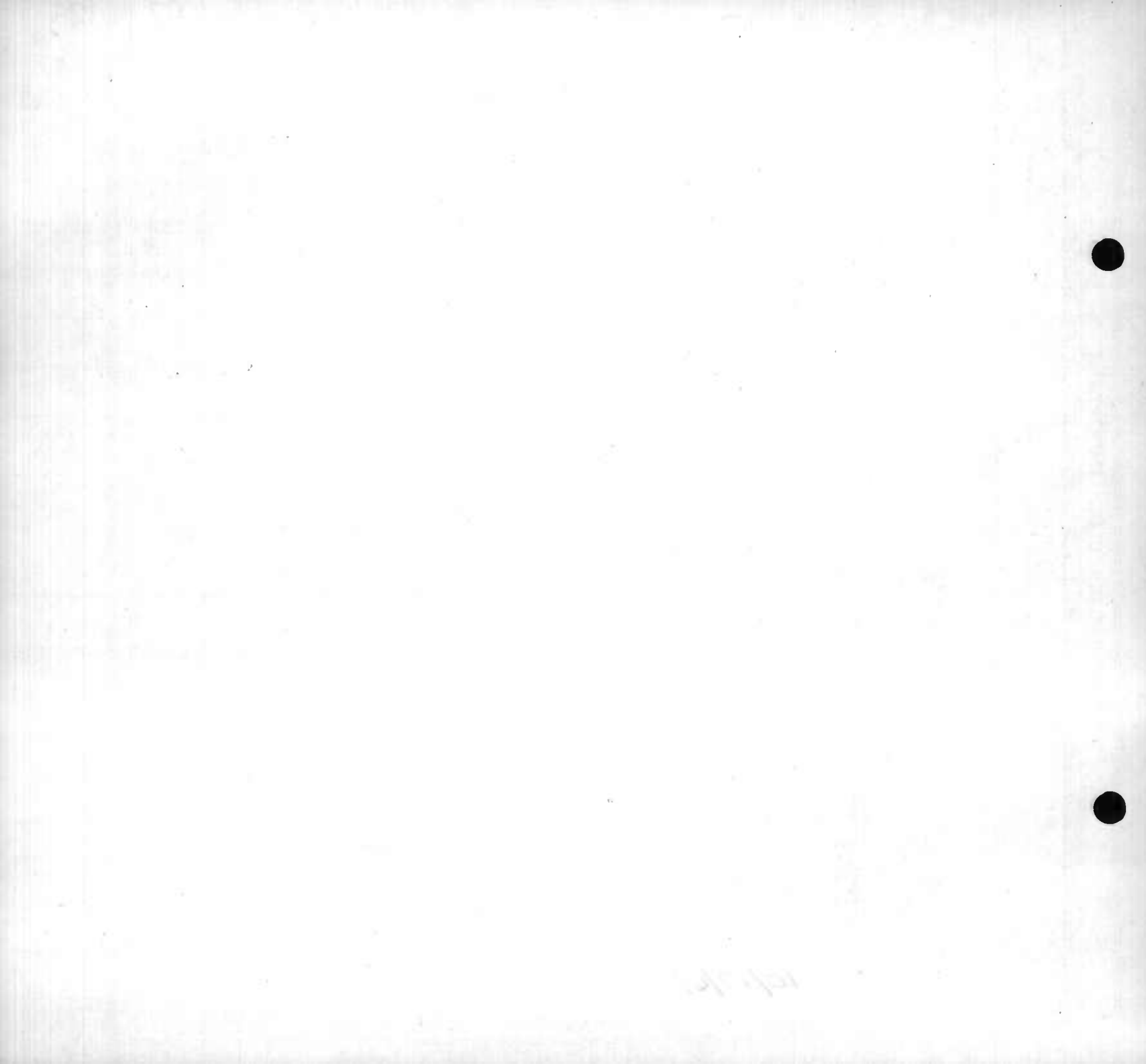
| | | | |
|--|---|------------------------------------|---|
| 23A. BURIAL CREMATION,
REMOVAL (Specify) | 23B. DATE
10/14/67 | 23C. NAME OF CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) (State)
ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL |
| 24A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | 24B. NAME OF REGISTRAR
Robert E. Feltner | 24C. FUNERAL DIRECTOR | ADDRESS
MORTUARY SERVICE - BCHD |

10/10/03

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67-2073267 10126 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10126 | |
|--|--|--|--|--|--|-------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | | |
| (Type or Print) | | | | BABY BOY JENKINS | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 2. DATE AND HOUR OF DEATH | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 38 University Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 13411 Mt 25-95 | | | |
| 2213 Hawkins PT Rd | | | | 8. DATE OF BIRTH | | | |
| 5. SEX | | | | 9. AGE (In years last birthday) | | | |
| M W | | | | 10/12/67 5 1/2 hrs | | | |
| 6. RACE | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| W | | | | University Hosp, Balto. U.S.A. | | | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| George Jenkins | | | | Carolyn Strevig | | | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| Father | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | PREMATURITY | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| | | | | PREMATURITY | | | |
| | | | | (C) DUE TO | | | |
| | | | | | | | |
| II | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | 5 hrs 31 min | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 19A. DATE OF OPERATION | | | | 20A. AUTOPSY? (Yes or No) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | |
| 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Reynaldo O. Guzman M.D. | | | | 10/12/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| REYNALDO O. GUZMAN M.D. | | | | UNIVERSITY MEDICAL SCHOOL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | |
| 10/17/67 | | | | 24C. NAME of CEMETERY or CREMATORY | | | |
| 24D. LOCATION (City, town, or county) (State) | | | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| OCT 24 1967 | | | | 25B. NAME OF REGISTRAR | | | |
| Robert E. Fairbank | | | | 25C. FUNERAL DIRECTOR | | | |
| MORTUARY SERVICE - BCHO | | | | ADDRESS | | | |



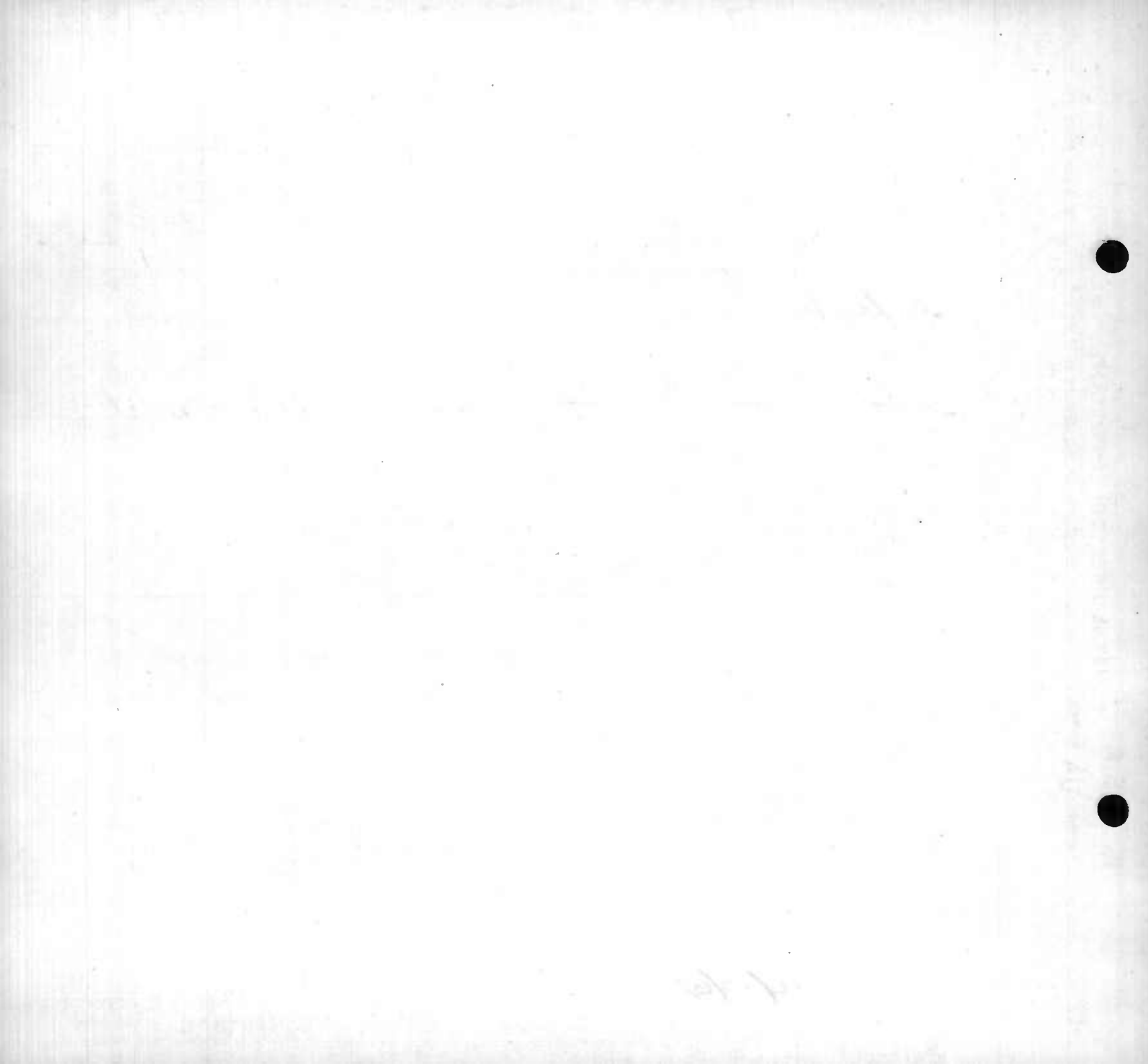
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------------|---|--|---|--|
| BIRTH NO. <u>67-19889</u> | | BALTIMORE CITY HEALTH DEPT. | | Registered No. <u>67 10127</u> | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Baby Boy Brown</u> | | | 2. DATE AND HOUR OF DEATH
<u>10/6/67</u> <u>1</u> <u>7</u> <u>P</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> (If not in hospital or institution, give street address or location)
<u>38</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>15-01</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>
D. STREET ADDRESS (If rural, give location) <u>1526 N. Stricker St</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W N</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) <u>—</u> | 8. DATE OF BIRTH <u>10/5/47</u> | 9. AGE (In years last birthday) <u>1</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | |
| 13. FATHER'S NAME <u>Walter Barnett</u> | | | 14. MOTHER'S MAIDEN NAME <u>Christine Brown</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT ADDRESS <u>patient's chart or mother</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Respiratory Distress Syndrome</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Immaturity</u> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>10/3/67</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u> | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>—</u> | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>10/5</u> 19 <u>67</u> to <u>10/6</u> 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>10/6</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Alfred R. Rosenberg</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>10/6/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Alfred R. Rosenberg</u> | | | | 23D. ADDRESS <u>—</u> M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>10/12/67</u> | | 24B. DATE <u>10/12/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>—</u> | |
| 24D. LOCATION (City, town, or county) <u>—</u> | | 24E. STATE (State) <u>—</u> | | 24F. ADDRESS <u>—</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>10/24/67</u> | | 25B. NAME OF REGISTRAR <u>A. B. E. F. Brown</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>—</u> | |

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

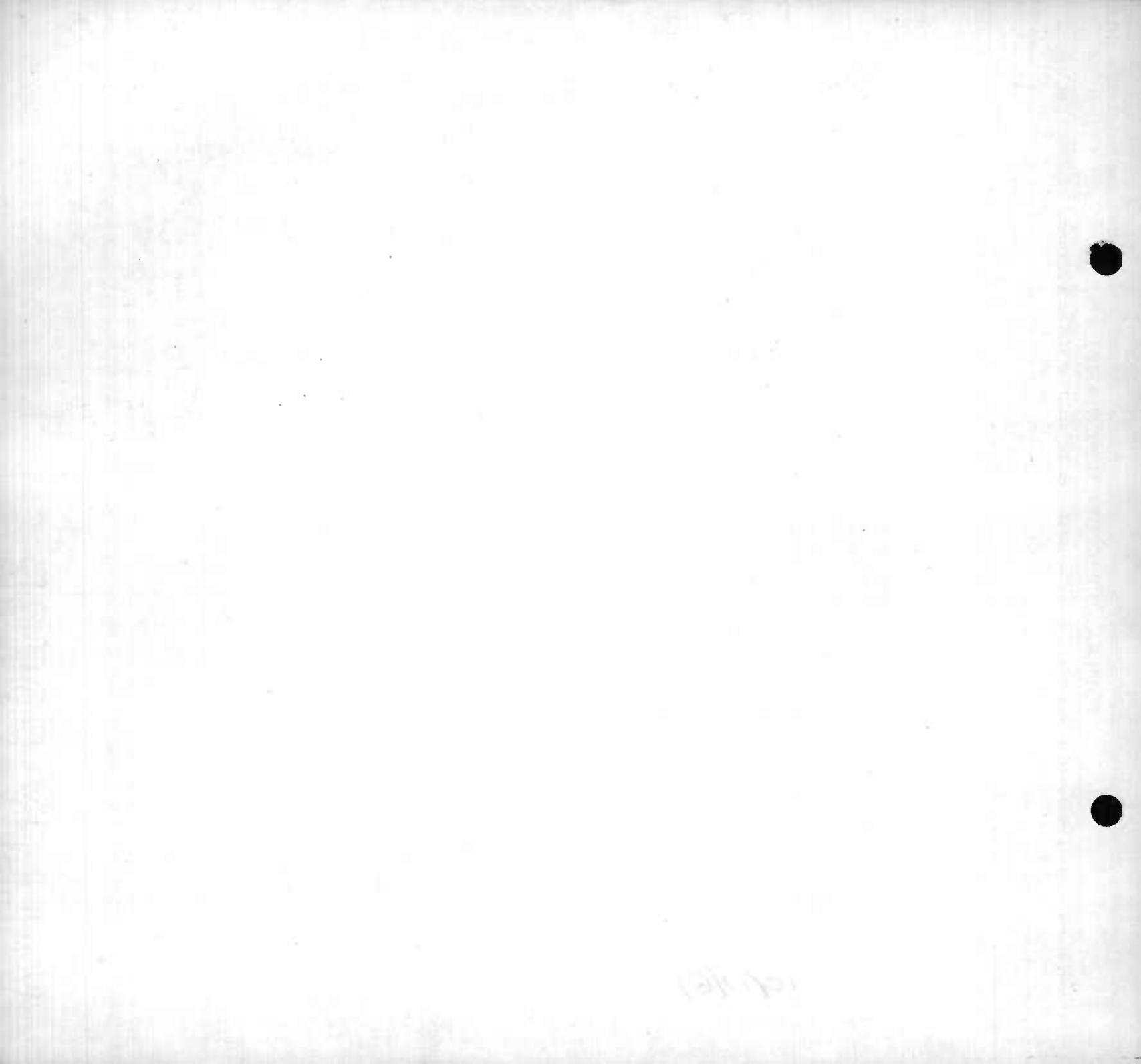


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|---|---|---|
| BIRTH NO. <u>67-20440</u> <u>67 10128</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>67 10128</u> | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Bailey, Baby Boy</u> | | | 2. DATE AND HOUR OF DEATH
<u>10/11/67</u> <u>12:40 P. M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>38 Univ. of Md. Hosp.</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>Balto. City</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u> <u>15-01</u>
D. STREET ADDRESS (If rural, give location) <u>1606 Lorman Ct - 17</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>never married</u> | 8. DATE OF BIRTH
<u>10/9/67</u> | 9. AGE (In years last birthday)
<u>2</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | 13. FATHER'S NAME
<u>Marrin Farley</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>Jacqueline Bailey</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
<u>Jane McCaffrey, M.D. Univ. Hosp.</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Neonatal atelectasis</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Prematurity</u> | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>2 days</u> | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>10/9</u> <u>1967</u> to <u>10/11</u> <u>1967</u> , that (I) <u>we</u> last saw the deceased alive on <u>10/11</u> <u>1967</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Jane E. McCaffrey</u> | | | 23B. DATE SIGNED
<u>10/11/67</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Univ. of Md. Hosp. Baltimore</u> | | | 23D. ADDRESS
<u>Univ. of Md. Hosp. Baltimore</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>10/12/67</u> | | 24C. NAME of CEMETERY or CREMATOR
<u>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u> | |
| 24D. LOCATION (City, town, dist. county) | | 24E. STATE | | 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 24 1967</u> | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Farley</u> | | 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|---|---|--|--|
| BIRTH NO. 67-20898 67 10129 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10129 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) BABY BOY BROWN | | 2. DATE AND HOUR OF DEATH
Oct. 18, 1967 25 a.m. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNION MEMORIAL Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 13-07
D. STREET ADDRESS (If rural, give location)
707 BERRY STREET | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
NM | 8. DATE OF BIRTH
Oct 16/67 | 9. AGE (In years last birthday)
39 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
- | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
EARL BROWN | | | 14. MOTHER'S MAIDEN NAME
SANDERS. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
A. FINKEL | | ADDRESS
UNION MEMORIAL |
| 18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ATELECTASIS of lungs
CARDIAC ARREST
prematurity
HYALINE MEMBRANE DISEASE
39 hrs.
W. K. Wee | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
30 mins. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 16 1967 to Oct 18 1967, that (I) (we) last saw the deceased alive on Oct 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
A. Finkel | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
Oct 18/67 | |
| 23C. PHYSICIAN'S NAME (Type)
ANNETTE FINKEL M.D. | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL
UNIVERSITY MEDICAL SCHOOL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
10/17/67 | | 24B. DATE
10/17/67 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE BOARD OF MARYLAND | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
Robert E. Finkler, M.D. | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHO | |

101 BERRY STREET
CORP
MILWAUKEE

M W NM

2000-2

WALK BELOW

A FINE

GRASSHOPPER

WYOMING - MONTANA

CHAS. CO. 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

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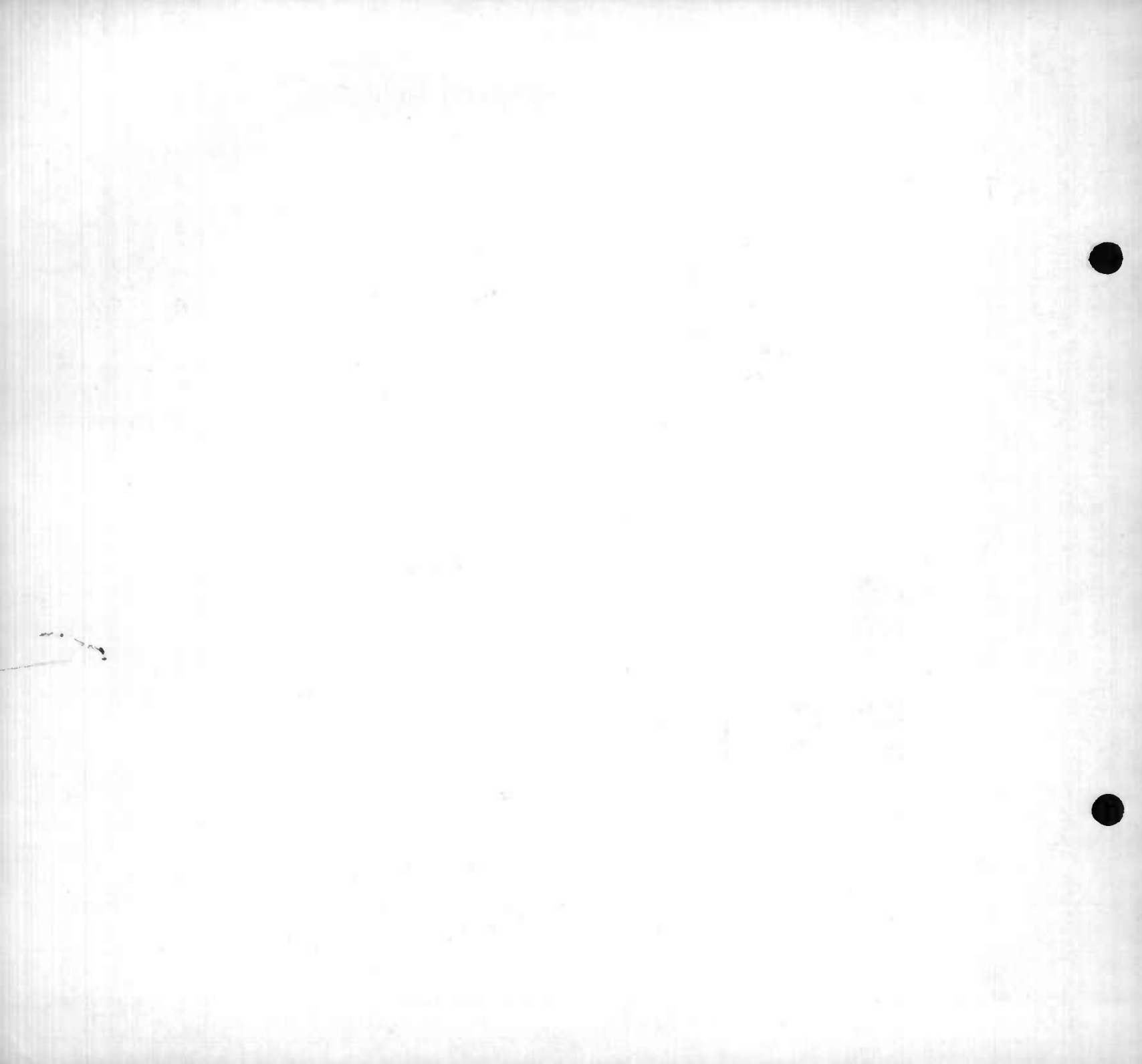
THE 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|---------------------|---|------------------------------------|---|---|
| BIRTH NO. 67-20294 | | 67 10130 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) BABY BOY CURRY | | 2. DATE AND HOUR OF DEATH
10-9-67, 7 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
LUTHERAN HOSPITAL OF MARYLAND | | A. STATE MARY LAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-10
D. STREET ADDRESS (If rural, give location) 3302, OAKFIELD AVENUE | | | |
| 5. SEX
MALE | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) — | 8. DATE OF BIRTH
10-7-67 | 9. AGE (In years last birthday)
3 days | If Under 1 Yr. Months Days Hours Min. 3 days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
LUTHERAN HOSPITAL OF MARYLAND | |
| 13. FATHER'S NAME
WALTER CURRY | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 14. MOTHER'S MAIDEN NAME
LILA | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. 726X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
PREMATURITY | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-7- 19 67 to 10-9- 19 67 , that (I) (we) last saw the deceased alive on 10-9- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Thankam B. Pillai | | | | 23B. DATE SIGNED
10-9-67 | |
| 23C. PHYSICIAN'S NAME (Type)
THANKAM B. PILLAI | | | | 23D. ADDRESS
LUTHERAN HOSPITAL OF MARYLAND | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
10/19/67 | | 24C. NAME OF CEMETERY or CREMATORY | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
P. E. F. F. F. | | 25C. FUNERAL DIRECTOR ADDRESS
UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------|--|----------------------------|---|---|
| BIRTH NO. 67-18647 67 10131 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10131 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) BABY BOY HARRIS | | 2. DATE AND HOUR OF DEATH
9-8-67 6 ⁴⁰ PM | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Md.
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Sinai Hospital BALTO. INC | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto. | |
| | | D. STREET ADDRESS (If rural, give location)
3816 Belle Ave. | | 15-10 | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
infant. | 8. DATE OF BIRTH
9-8-67 | 9. AGE (In years last birthday)
6 | If Under 1 Yr. Months: 00ys If Under 24 Hrs. Hours: 30 Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
INFANT | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
GLORIA Harris | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
CHART | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
274X1 | | CAUSE OF DEATH
(A) IMMATURITY
DUE TO
(B) Maternal hemorrhage +
DUE TO
(C) premature LABOR. | | INTERVAL BETWEEN ONSET AND DEATH
6 hrs 30 min | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
NO | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
III in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
NONE | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-8-19 67 to 9-8-19 67, that (I) (we) last saw the deceased alive on 9-8-19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Hina C. Rawlings | | M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
9-8-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Hina C. Rawlings | | M.D. Sinai Hospital | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
10-23-67 | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY
JOHNS HOPKINS MEDICAL SCHOOL | |
| 24D. LOCATION
BALTIMORE, MARYLAND | | 24E. CITY, TOWN, or COUNTY | | 24F. STATE | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
R. E. E. F. F. | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE | |
| 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS | |

11. 12. 1911

11. 12. 1911

11. 12. 1911

11. 12. 1911

11. 12. 1911

11. 12. 1911

11. 12. 1911

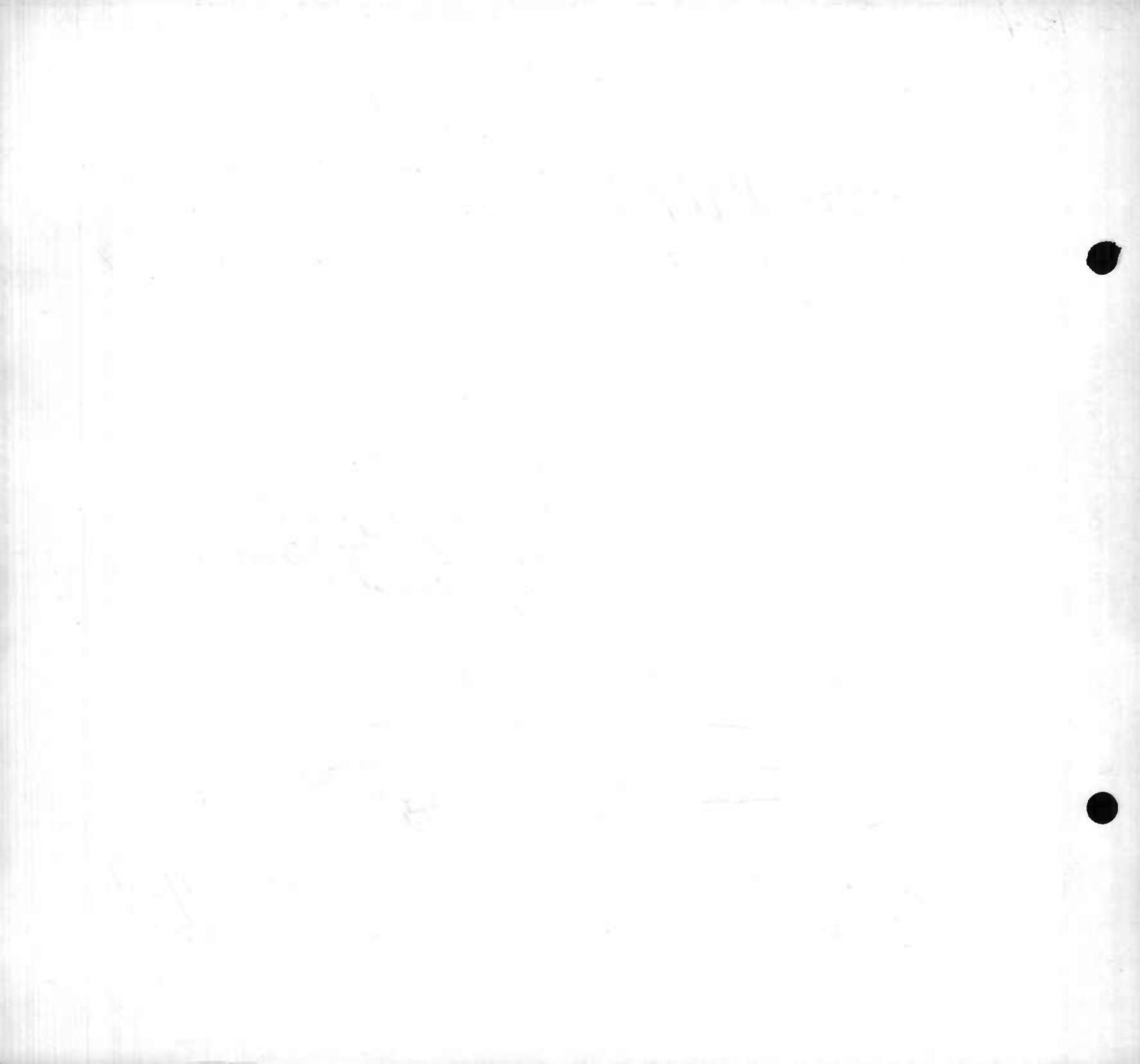
11. 12. 1911

11. 12. 1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

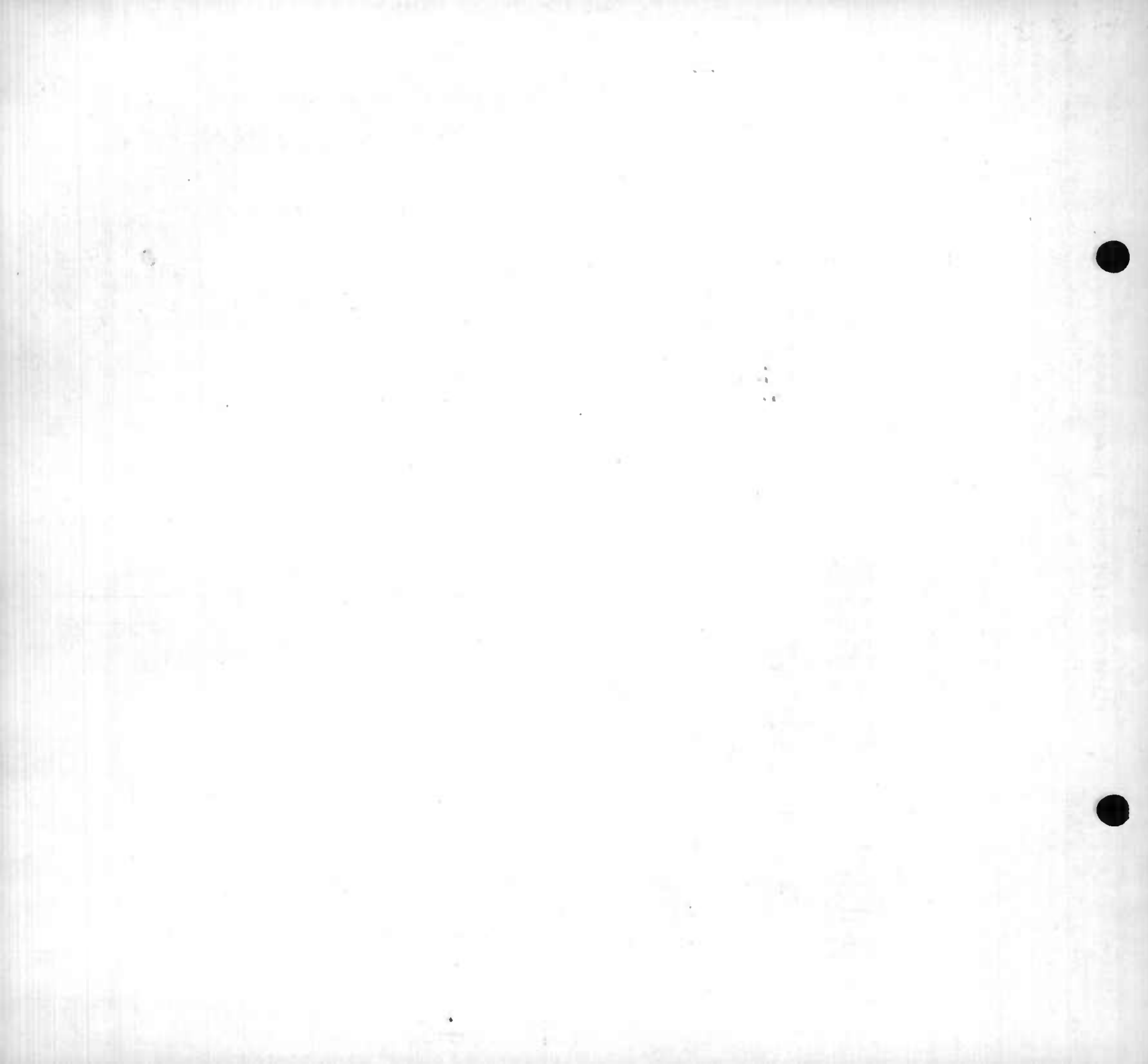
| | | | | | |
|--|-------------------------|---|------------------------------------|---|---|
| BIRTH NO. 67-19700 67 10132 | | CERTIFICATE OF DEATH | | Registered No. 67 10132 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
Baby Boy Caldwell | | 2. DATE AND HOUR OF DEATH
9/21/67 4:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE md.
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Sinai Hospital of Baltimore | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 21215 15-12 | |
| | | D. STREET ADDRESS (If rural, give location)
2917 NORFOLK AVE. | | | |
| 5. SEX
M | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Infant | 8. DATE OF BIRTH
9/21/67 | 9. AGE (In years lost birthday)
4 hours | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min.
4 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME
Unknown (Separated from husband) | | 14. MOTHER'S MAIDEN NAME
Marie Briggs | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Prematurity | | CAUSE OF DEATH
(A) DUE TO
Primary Apnea of Birth
(B) DUE TO
Respiratory Distress Syndrome
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Pending | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Sent | |
| 22. I certify that (I) (this hospital) attended the deceased from 12:50 AM 19 67 to 4:45 AM Sept 21 19 67 , that (I) (we) last saw the deceased alive on 4:40 A.M. Sept 21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joseph H. Richman M.D. | | | | 23B. DATE SIGNED
9/21/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Joseph H. Richman M.D. | | | | 23D. ADDRESS
Sinai Hospital of Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
10-23-67 | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY
JOHNS HOPKINS MEDICAL SCHOOL | |
| 24D. LOCATION
BCHD | | 24E. NAME of REGISTRAR
Robert E. Farley | | 24F. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 67-19788 67 10133 | | CERTIFICATE OF DEATH | | Registered No. 67 10133 | |
|--|------------------------|---|---|--|--|--|--|-------------------------|--|
| 1. NAME OF DECEASED
(Type or Print) Barry Roy Boyd | | | | 2. DATE AND HOUR OF DEATH
9-30-67 3:17P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNIVERSITY HOSPITAL 38 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE CITY 18-03 | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
119 CARROLLTON AVE. 21223 | | | | | |
| 5. SEX
Male | 6. RACE
NEGR | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
N/A | 8. DATE OF BIRTH
9-30-67 | 9. AGE (In years last birthday)
N/A | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
N/A | | | 10B. KIND OF BUSINESS OR INDUSTRY
N/A | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S. & A. | | |
| 13. FATHER'S NAME
ALVIN BROWN | | | | 14. MOTHER'S MAIDEN NAME
VIOLA BOYD | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
N/A | | 16. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
GARY A. FLEMING | | ADDRESS
UNIV. HOSP. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
IMMATURITY | | | | CAUSE OF DEATH
(A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
29 hours 56 min | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
RESPIRATORY DISTRESS | | | | (B) DUE TO | | 29 hours 56 min | | | |
| | | | | (C) | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
PREMATURE RUPTURE MEMBRANES | | | | | | | | | |
| 19A. DATE OF OPERATION
N/A | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20A. AUTOPSY? Yes or No
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
N/A | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
N/A | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
N/A | | 21C. WHERE DID INJURY OCCUR?
N/A | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
N/A | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>
N/A | | 21F. HOW DID INJURY OCCUR?
N/A | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-29 1967 to 9-30 1967 , that (I) (we) last saw the deceased alive on 9-30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
GARY A. FLEMING | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
9-30-67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
GARY A. FLEMING | | | | 23D. ADDRESS
UNIVERSITY HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
10/9/67 | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY
JOHNS HOPKINS MEDICAL SCHOOL | | 24D. LOCATION (City, town, or county) (State)
HOSPITAL DISPOSAL | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
HOSPITAL DISPOSAL | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67-25147 67 10134 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10134 | |
|---|-------------------------|--|---|---|---|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Baby Boy Barnes "B" | | | | 2. DATE AND HOUR OF DEATH
10/5/67 5:53 p.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
38 Univ. of Md. Hosp. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY Baltimore City
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
25 N. Broadway | | | |
| 5. SEX
M | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
never married | 8. DATE OF BIRTH
10/5/67 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MD. | | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
Louis Crawley | | | | |
| 14. MOTHER'S MAIDEN NAME
Mary Barnes | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
25 N. Broadway
ADDRESS | | | | |
| 18. 776X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Immaturity | | | | INTERVAL BETWEEN ONSET AND DEATH
2 hrs. - 23 min | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO
(B) DUE TO
(C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from 3:30 p.m. 10/5/67 to 5:53 p.m. 10/5/67 , that (I) <u>two</u> last saw the deceased alive on 10/5 19 67 and that in (my) <u>four</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>W</u> <u>did</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Jane B. McElhenny | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/5/67 | |
| 23C. PHYSICIAN'S NAME (Type)
University of Md. Hosp. | | | | 23D. ADDRESS
UNIVERSITY MEDICAL SCHOOL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
10/9/67 | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State)
HOSPITAL DISPOSAL | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
Philip E. Farkner | | 25C. FUNERAL DIRECTOR | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------|--|--------------------------|--|--|--|----------------------------------|
| BIRTH NO. 67-25146 | | 67 10135 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10135 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Baby Boy Barnes "A" | | | |
| 2. DATE AND HOUR OF DEATH 10/5/67 10:30 p. M. | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 Univ. of Md. Hosp. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. City | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | D. STREET ADDRESS (If rural, give location) 25 N. Broadway | | | |
| 5. SEX M | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married | 8. DATE OF BIRTH 10/5/67 | 9. AGE (In years last birthday) 3 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Louis Crawley | | | | 14. MOTHER'S MAIDEN NAME Mary Barnes | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS 25 N. Broadway | |
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH (A) Immaturity DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 3 hrs - 4 min. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| (C) DUE TO | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3:26 p.m. 10/5/19 67 to 6:30 a.m. 10/5/19 67, that (I) (we) lost saw the deceased alive on 10/5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Jane B. Mc Caffrey | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 10/5/67 | |
| 23C. PHYSICIAN'S NAME (Type) Univ. of Md. Hosp. | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 10-9-67 | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| OCT 24 1967 | | | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|--|--|--|
| BIRTH NO. 67 10136 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10136 | |
| 1. NAME OF DECEASED
(Type in Print) NOAKIA ROSE NAPORA | | | 2. DATE AND HOUR OF DEATH
10-20-67 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location)
00219 Calgate Ave. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
520 S. MADEIRA ST. | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
4-10-1896 | 9. AGE (In years last birthday)
71 | 10. Under 1 Yr. Months Days Hours Min.
1-04 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOMEMAKER | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
POLAND |
| 13. FATHER'S NAME
JOHN ZACHOWSKI | | | 14. MOTHER'S MAIDEN NAME
MARYANN ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
218-05-9866 | | 17. INFORMANT
MRS. GENEVIEVE SPICKA
ADDRESS
1122 HALSTEAD RD. #34 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Chronic Pulmonary Edema | | | CAUSE OF DEATH
(A) DUE TO
Congestive heart failure
(B) DUE TO
Hypertension
(C) Arteriosclerosis | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 20 1966 to Oct. 29 1967 , that (I) (we) last saw the deceased alive on Oct. 29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Benigno R. Lazaro | | | | 23B. DATE SIGNED
10-20-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Benigno R. Lazaro | | | 23D. ADDRESS
59 Dundalk Avenue | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-23-67 | | 24C. NAME OF CEMETERY or CREMATORY
ST. STANISLAUS CEMETERY | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairbank | |
| 25C. FUNERAL DIRECTOR
RAYMOND L. KACZOROWSKI | | 25D. ADDRESS
2525 FLEET ST. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be given by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. | |
|---|--|---|---|---|--|
| BIRTH NO. G-650 | | 67 10137 | | 67 10137 | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) GREEN, CHARIE LEE | | | 10/19/67 11:20 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
MERCY HOSP. | | | A. STATE MD. | | |
| | | | B. COUNTY BALTO. | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | CATONSVILLE 53-00 | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 1926 ALTAVUE RD. | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
7/5/1894 | 9. AGE (In years last birthday)
73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
ALFRED T. MATTHEWS | | | 14. MOTHER'S MAIDEN NAME
ELIZABETH PARKER YOUNG MATTHEWS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 17. INFORMANT ADDRESS
Dr. J. Leas Green (Husband) 1926 Altavue Rd. Catonsville, Md. | | |
| 16. SOCIAL SECURITY NO.
219-34-4186B | | | | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. | | | CAUSE OF DEATH
(A) DUE TO Myocardial infarction
(B) DUE TO ASCVD
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
16 days
years |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic Cholelithiasis | | | | | |
| 19A. DATE OF OPERATION
9/28/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cholelithiasis | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
White <input type="checkbox"/> Not White <input type="checkbox"/>
Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/25 19 67 to 10/19 19 67 , that (I) (we) lost saw the deceased alive on 10/19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
M. Susan Bollinger M.D. | | | | 23B. DATE SIGNED
10/20/67 | |
| 23C. PHYSICIAN'S NAME (Type)
M. SUSAN BOLLINGER M.D. | | | | 23D. ADDRESS
Mercy Hosp | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Oct. 23, 1967 | | 24C. NAME OF CEMETERY or CREMATORY
Liberty Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Parksley, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairburn | | 25C. FUNERAL DIRECTOR ADDRESS
HOLLOWAY & COMPANY, SALISBURY, MARYLAND | |

1871 Nov 10

Received of Mr. J. C. [illegible]

the sum of \$100.00

for [illegible]

and [illegible]

for [illegible]

for [illegible]

for [illegible]

for [illegible]

for [illegible]

102067

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10138 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10138 | |
|--|---------|--|-----------------------------------|---|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) Wall, John | | | | | | 10/21/67 14:45 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| THE JOHNS HOPKINS HOSPITAL | | | | MARYLAND | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 3708 CRANSTON AVENUE 21229 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| MALE | NEGRO | MARRIED | 11-16-25 | 41 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | |
| Meat Packer | | | Meat Plant | | North Carolina | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| WILLIAM WALL | | | | Dizzie Baldwin | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| Yes | | WW II | | Annette Wall | | Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | (A) Subarachnoid hemorrhage 20 hrs | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 20 19 67 to Oct 21 19 67, that (I) (we) last saw the deceased alive on Oct 21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Elizabeth H. Jansson M.D. | | | | 23B. DATE SIGNED 10/21/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) Elizabeth H. Jansson M.D. | | | | 23D. ADDRESS 4, Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 10-25-67 | | Poplar Springs Cem. | | Rockingham N. Carolina | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 24 1967 | | 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| | | | | Watson & Kane Funeral Home | | Rockingham N.C. | |

Wilson Funeral Home

This case was released by Dr. Springate on 12-25-94 (1994)
Pius y Cho

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| 7-635-67 10139 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10139 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED | |
| 67 10139 | | Minnie | | Trautman Mary M | |
| 2. DATE AND HOUR OF DEATH | | 10/14/1967 11 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| CITY OF TOWN | | A. STATE B. COUNTY | | | |
| BALTIMORE | | M.D. | | | |
| D. STREET ADDRESS | | (If outside city limits, write RURAL and give township) | | | |
| 3307 Gibbons Ave. | | 27-44 | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED | |
| female | | white | | WIDOWED, DIVORCED (specify) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| | | | | 5/27/1886 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| | | unknown | | 83 81 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | | | Delores Greghegan (daughter) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | RUPTURE OF POSTERIOR COMMUNICATING CEREBRAL ARTERY | | Michael Newman | |
| ANTECEDENT CAUSES | | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 NO | | | | yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| yes | | Home | | home (Baltimore city) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 7.30 AM 10/14/67 | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | fell down 14 steps | |
| 22. I certify that (I) (this hospital) attended the deceased from 8:04 AM 10/14 1967 to 1 P.M. 10/14 1967, that (I) (we) last saw the deceased alive on 1 P.M. 10/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Pius y Cho | | | | 10/14/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | M.D. THE UNION MEMORIAL HOSPITAL | | | |
| PIUS Y-H CHO | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 10/18/67 | | Parkwood | |
| 25A. DATE OF DEATH | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| OCT 24 1967 | | Robert E. Farley M.D. | | Philip Herwig Sons | |
| | | | | ADDRESS 2024 Orleans St | |

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J-530

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10140

| | | | |
|---|---------|---|------------------|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| MAMIE E. JOYNES | | October 20, 1967 5:55 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE
Maryland | |
| 00 3321 Dolfield Avenue | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore | |
| | | D. STREET ADDRESS (If rural, give location)
3321 Dolfield Avenue | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| Female | Negro | | 8-7-1902 |
| 9. AGE (In years last birthday) | | 10. AGE (In years last birthday) | |
| 65 | | 65 | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| BALTIMORE | | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| JOHN F. JOYNES | | BLANCHE M. HENSON | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| NO | | | |
| 17. INFORMANT | | ADDRESS | |
| BLANCHE M. JOYNES | | 3321A DOLFELD AVE | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic heart disease
DUE TO | | | |
| II
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 0 | | | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| No | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| | | | |
| 21F. HOW DID INJURY OCCUR? | | | |
| | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| Charles S. Springate | | | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | |
| Burial | | 10/24/1967 | |
| 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Mt Auburn | | BALTIMORE | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| OCT 24 1967 | | R. E. Finkbeiner | |
| 24C. FUNERAL DIRECTOR | | ADDRESS | |
| Mansueti & Hays | | 638 N. Calver St | |

19670010161

THE HISTORY OF THE

REPUBLIC OF THE

UNITED STATES OF AMERICA

1776-1783
The American Revolution
The Declaration of Independence
The Constitution

1783-1789
The Federalist Papers
The Bill of Rights

1789-1800
The Presidency of George Washington

1800-1809
The Presidency of John Adams

1809-1817
The Presidency of James Madison

1817-1825
The Presidency of James Monroe

1825-1837
The Presidency of James K. Polk

1837-1845
The Presidency of James K. Polk

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|-----------------------|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10141 | |
| BIRTH NO. 67 10141 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) WALLACE STEPHENS | |
| 2. DATE AND HOUR OF DEATH
10-22-67 1130 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION
1213 POPLAR GROVE ST | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location)
1213 Poplar Grove St | |
| 5. SEX
M | 6. RACE
col | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
9-17-1907 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY
ENTERPRISE FUEL | 9. AGE (In years lost birthday)
60 |
| 11. BIRTHPLACE (State or foreign country)
FLORIDA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JACK STEPHENS | | 14. MOTHER'S MAIDEN NAME
CHARMANN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
213-03-7395 | |
| 17. INFORMANT
BOULAN STEPHENS | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
151X I | | CAUSE OF DEATH
(A) Carcinoma of stomach
DUE TO
(B)
DUE TO
(C)
INTERVAL BETWEEN ONSET AND DEATH
about 8 months | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,
II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1967 to Oct 22 1967 , that (I) (we) last saw the deceased alive on Oct 21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Lucius W. Leeper | | 23B. DATE SIGNED
10/23/67 | |
| 24C. PHYSICIAN'S NAME (Type)
Lucius W. Leeper | | 23D. ADDRESS
1200 Stony Brook Rd. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10/26/67 | |
| 24C. NAME OF CEMETERY or CREMATORY
ARBURUS MEM PK | | 24D. LOCATION (City, town, or county) (State)
Baltimore 21227 | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 24 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
Thos. Lewis Peltzman | | ADDRESS
638 N. Giles St | |

Calvin / 1891

and 1/2

James W. Cooper

1891

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|----------------------|--|--|--|--|--|--|
| BIRTH NO. H-350 | | 67 10142 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10142 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) EMORY Hayden | | | | October 23, 1967 10 ³⁰ P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY Baltimore | |
| 102 N. Penn St. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 33-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3450 DUNNAN Rd | | | |
| 5. SEX MALE | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH Feb 21-1879 | 9. AGE (In years last birthday) 88 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationery Engineer | | | 10B. KIND OF BUSINESS OR INDUSTRY Canning | | 11. BIRTHPLACE (State or foreign country) Balto Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Hayden | | | 14. MOTHER'S MAIDEN NAME MARTIN Vaughn | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO None | | | 16. SOCIAL SECURITY NO. 217-01-5537 | | 17. INFORMANT Mrs Jeannette Budusky | | ADDRESS 3116 Hudson St |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cardio Respiratory Failure
Ac Myocardial Infarction
Postmyocardial CATH
Diabetes Mellitus | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 27 1965 to Oct 23 1967 , that (I) (we) last saw the deceased alive on Oct 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Willard Appleberry | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 10/24/67 | |
| 23C. PHYSICIAN'S NAME (Type) Willard Appleberry | | | | 23D. ADDRESS 5501 Park Heights Dr | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Oct 27-1967 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park | | 24D. LOCATION (City, town, or county) (State) BALTO. CO. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 24 1967 | | 25B. NAME OF REGISTRAR P. E. Fairbank | | 25C. FUNERAL DIRECTOR Geo. L. Schwab
Funeral Home
Francis W. Miller 2101 Frederick Ave. | | | |

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIE STATON

2. DATE AND HOUR PRONOUNCED DEAD

October 19, 1967

4:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

130 N. Aisquith Street, Apt. 4C

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Aug. 14, 1918

9. AGE (in years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Cemetery

11. BIRTHPLACE (State or foreign country)

Talbot Co. N. C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Staton

14. MOTHER'S MAIDEN NAME

~~Mabel Staton - 130 N. Aisquith St.~~ Unknown15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

246-18-1848

17. INFORMANT

ADDRESS

Mabel Staton - 130 N. Aisquith St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 20, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10-25-67

23C. NAME of CEMETERY or CREMATORY

Wilson Cemetery

23D. LOCATION

(City, town, or county)

(State)

Princeton, N. C.

24A. DATE REC'D BY HEALTH DEPT.

OCT 24 1967

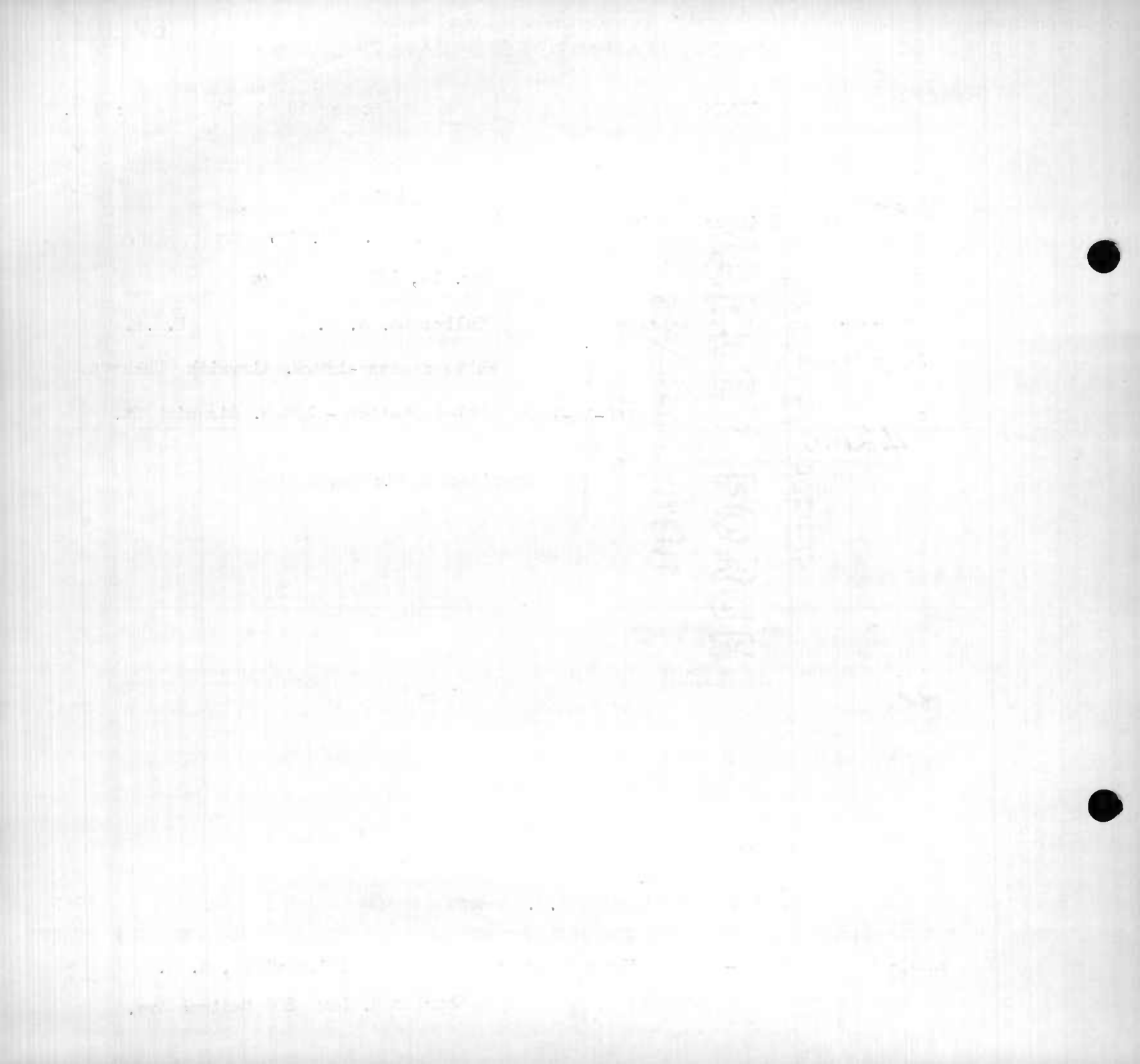
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Charles R. Law 802 Madison Ave.

ADDRESS



1
P-636

67 10144 BALTIMORE CITY HEALTH DEPARTMENT

67 10144

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD PROTHER PRATHER

2. DATE AND HOUR PRONOUNCED DEAD

October 20, 1967

3:00 A.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 428 W. Camden Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

424 W. Camden Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

#?# 3/4/05

9. AGE (in years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

217-01-5214

17. INFORMANT

ADDRESS

Carrie Hargrave 424 W. Camden St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Hypertensive and arteriosclerotic

(A) DUE TO cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 20, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/26/67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION (City, town, or county)

Brooklyn, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 24 1967

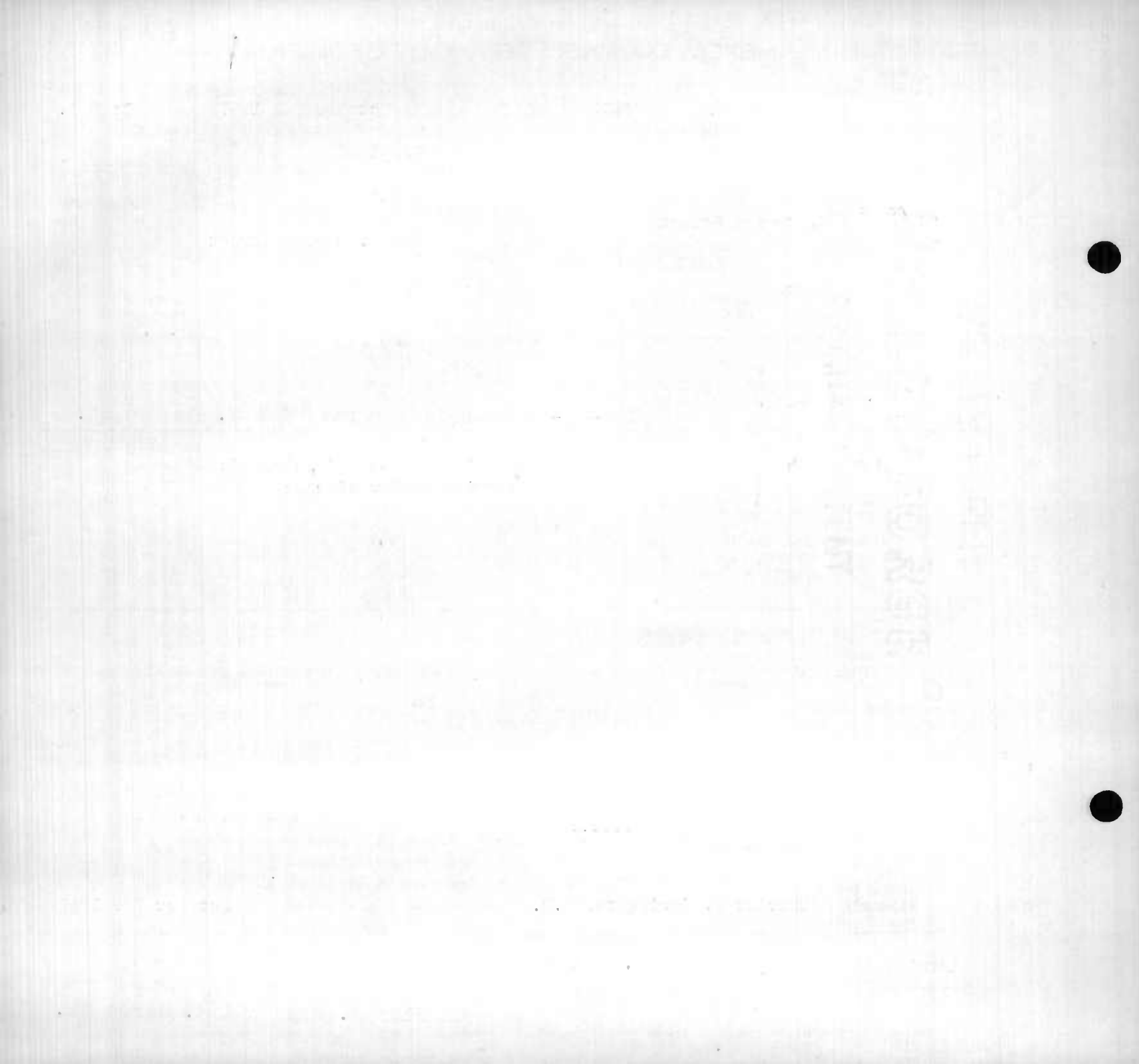
24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

Charles A. Rice 661 W. Barre St.

ADDRESS



1
H-630
64-12520

67 10145

BALTIMORE CITY HEALTH DEPARTMENT

67 10145

BIRTH NO. 64-12520 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) VICTOR HOWARD 2. DATE AND HOUR PRONOUNCED DEAD October 21, 1967 11:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-02

D. STREET ADDRESS (If rural, give location) 640 Pitcher Street

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single 8. DATE OF BIRTH 5/15/64 9. AGE (in years last birthday) 3

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Ratley 14. MOTHER'S MAIDEN NAME Palace Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS Palace Ratley 640 Pitcher St.

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Second Degree Burns of 50% of Body XXXXX Surface

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 640 Pitcher Street 14-02

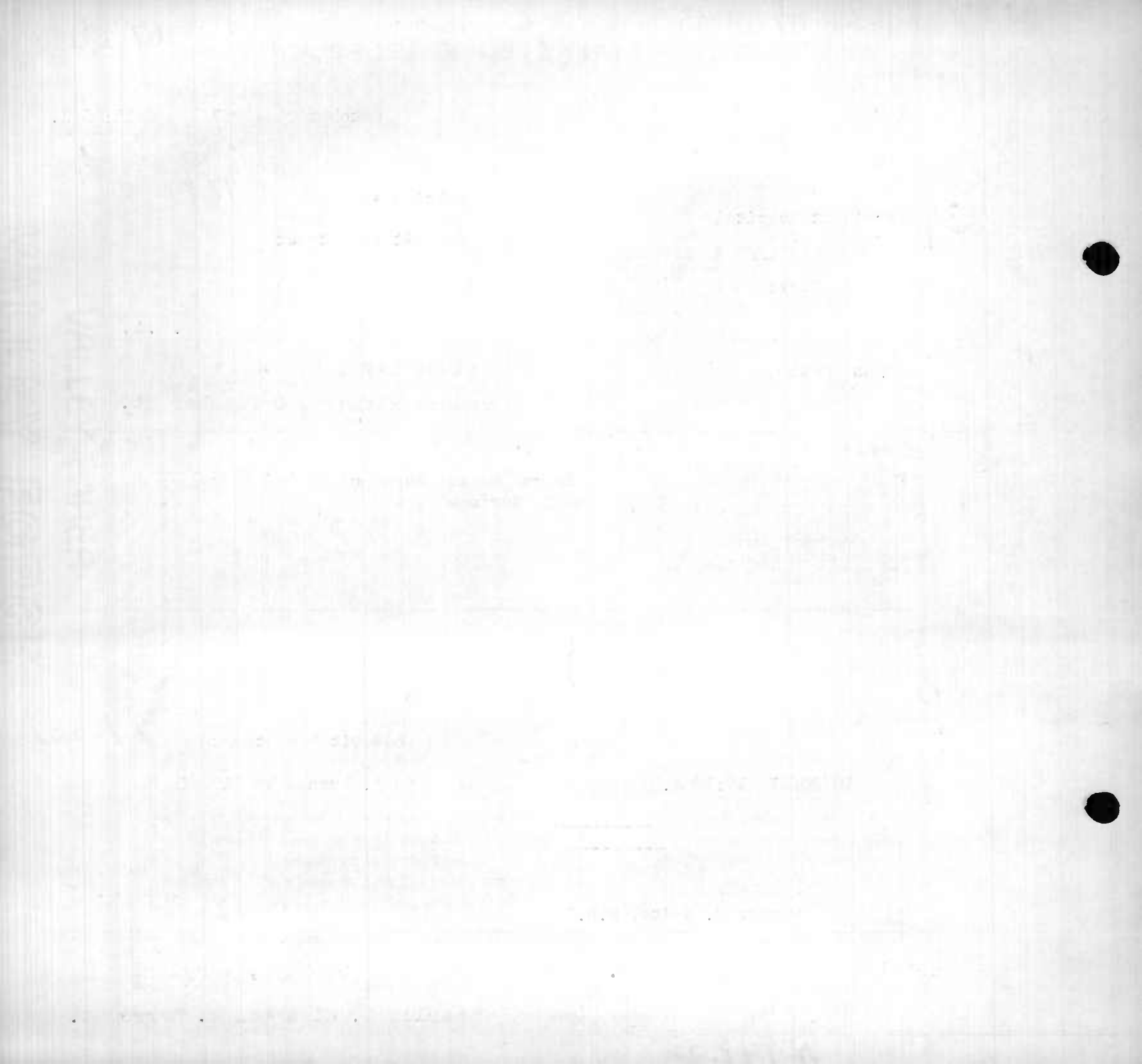
21D. TIME OF INJURY (APPROX.) 10/20/67 10:10 A.M. 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR? Subj. burned by fire in home

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER DATE SIGNED 10/22/67 ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 10/24/67 23C. NAME OF CEMETERY or CREMATORY Mt. Calvary 23D. LOCATION (City, town, or county) (State) Brooklyn, Maryland

24A. DATE REC'D BY HEALTH DEPT. OCT 24 1967 24B. NAME OF REGISTRAR Robert E. Fisher, M.D. 24C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St.

N 948.2 67 10145

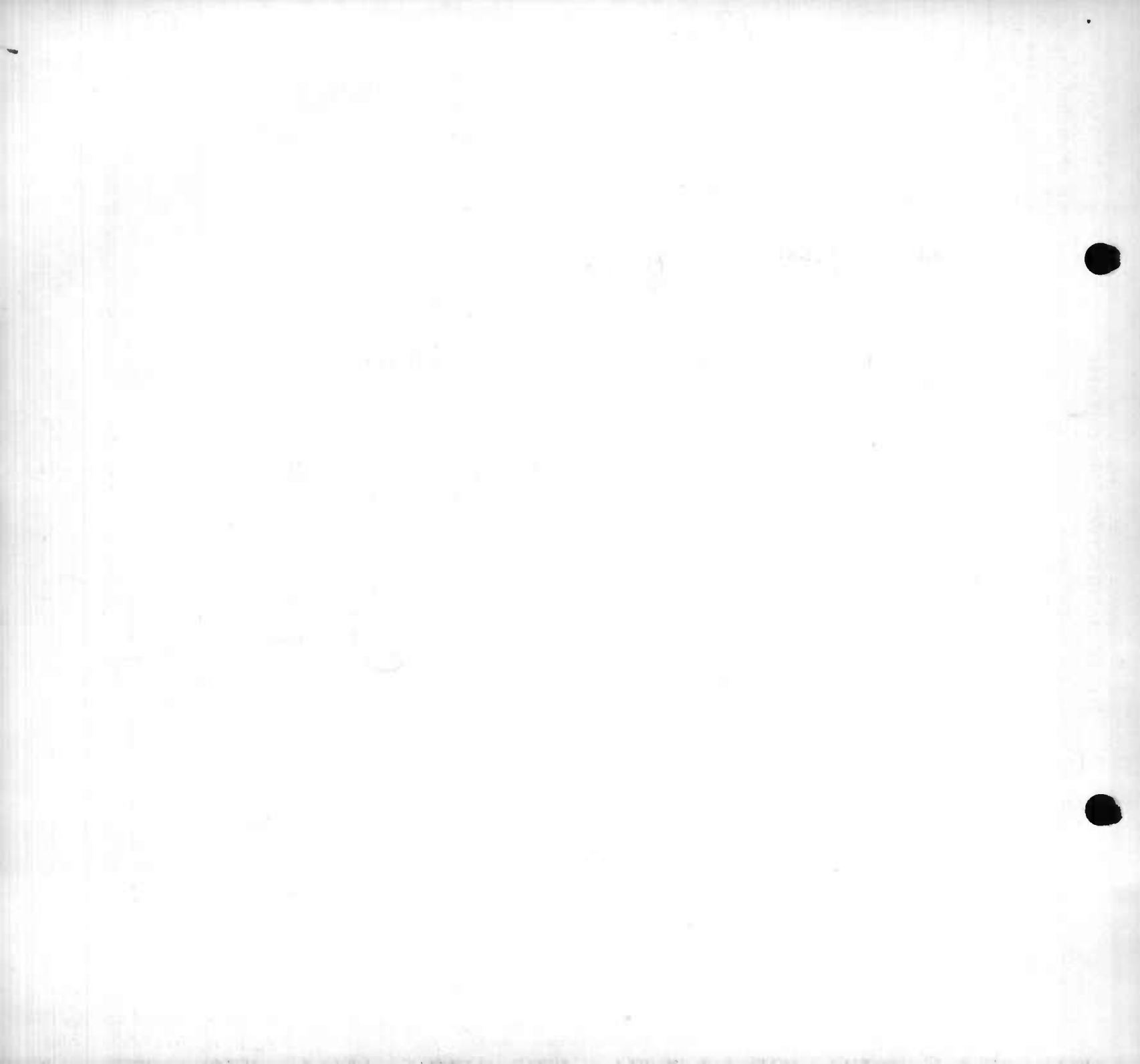


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 10146</u> | |
|--|-------------------------|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>67 10146</u> CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) <u>Arthur OWENS</u> | | | 2. DATE AND HOUR OF DEATH
<u>10/18/67</u> <u>5:30 P.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

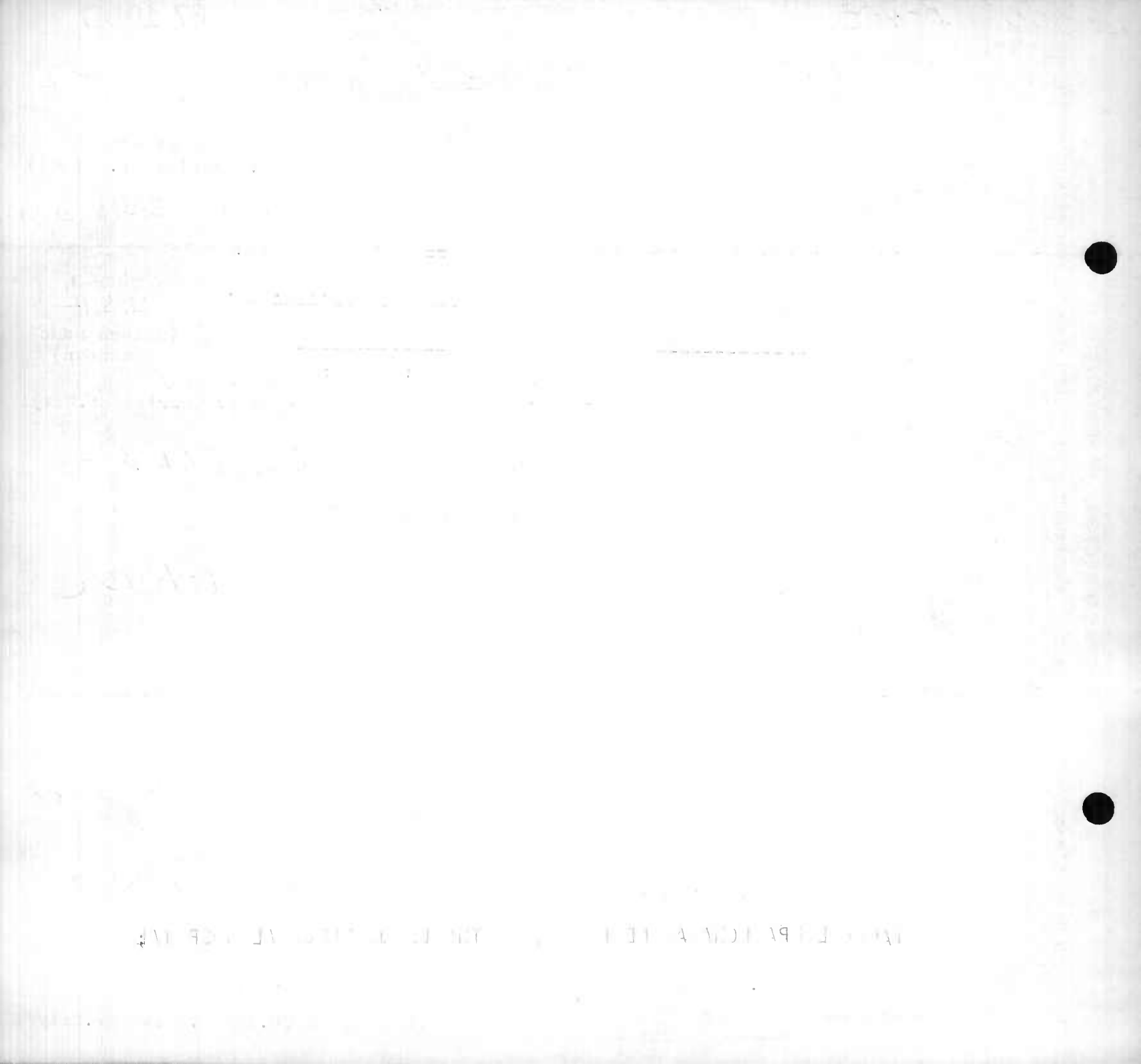
<div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION
 <u>38 University Hospital</u> </div> <div> (If not in hospital or institution, give street address or location) </div> </div> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>BALT.</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>
D. STREET ADDRESS (If rural, give location) <u>16-07 3015 BRIGHTON ST.</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>NEGRO</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>7-4-87</u> | 9. AGE (In years last birthday)
<u>80</u> | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>?</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<u>S. Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>JOHN OWENS</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Janie Small</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. <u>181.0 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>TRANSITIONAL CELL CARCINOMA of Bladder, Recurrent.</u> | | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH
<u>14 months</u> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Arteriosclerotic Cardiovasc. Dis. Cerebrovascular Insufficiency</u> | | | | | |
| 19A. DATE OF OPERATION
<u>9-20-67</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>CA OF Bladder.</u> | 20A. AUTOPSY (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>7-15</u> 19 <u>67</u> to <u>10-15</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/18/67</u> 19 <u>67</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did not</u>) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Joseph Insoft</u> | | | | 23B. DATE SIGNED
<u>10-19-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>Oct 23, 1967</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Mt. Auburn Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Westport (Baltimore) Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 24 1967</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Farnham</u> | | 25C. FUNERAL DIRECTOR
<u>Joseph L. Kries 2222 W. Main Ave. Baltimore, Md.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|----------------------|--|--|--|--|--|--|
| BIRTH NO. B-453 | | 67 10147 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10147 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ALIAS: LOUDY, ELLA M. (EMMA MAE BLAND) | | | | 2. DATE AND HOUR OF DEATH 10/16/67 1:10 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | (If not in hospital or institution, give street address or location) | | A. STATE Md. | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto (1823 N. Charles St. 21201) | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1823 N Charles St. 21218 (21201) | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow (?) | | 8. DATE OF BIRTH 3/18/03 | | 9. AGE (In years last birthday) 64 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) TUCKER CO., W. VA. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George W. Lechlitter | | | | 14. MOTHER'S MAIDEN NAME Belle (maiden name unknown) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) NO - DOUBTFUL | | | | 16. SOCIAL SECURITY NO. 213 - 22 - 3127 | | 17. INFORMANT Friend: Harry E. Loudy ADDRESS 1823 N. Charles St. Cityl | |
| 18. 464 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES | | | | (A) DUE TO pulmonary embolism, bilateral | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO Thrombophlebitis | | | |
| | | | | (C) W.K.W. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/15 19 67 to 10/16 19 67 . | | that (I) (we) lost saw the deceased alive on 10/16 19 67 and that in (my) (our) opinion death occurred on the date | | and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Limpawichara M.D. | | | | 23B. DATE SIGNED 10/16/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) TAWEE LIMPAWICHARA MD. D. CHART | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Oct. 21 1967 | | 24C. NAME of CEMETERY or CREMATORY LOUDON PARK CEMETERY | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 24 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR STEWART & MOWEN CO. | | ADDRESS 108 W. North Av. City 1 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--------------|--|----------------------------------|---|---|
| BIRTH NO.
67 10148 | | 67 10148 | | 67 10148 | |
| M.E. CASE NO. | | 67 10148 | | 67 10148 | |
| 1. NAME OF DECEASED
(Type or Print) | | Virginia E. Kemp | | 2. DATE AND HOUR OF DEATH
October 23, 1967 8:00 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

2617 Maryland Ave. | | A. STATE
Maryland | | | |
| (If not in hospital or institution, give street address or location) | | B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 2617 Maryland Ave. | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Jan. 4, 1884 | 9. AGE (In years last birthday)
83 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Trenton, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
John Thomas Martin | | 14. MOTHER'S MAIDEN NAME
Penelope Kemp | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-07-0119 | | 17. INFORMANT
Mrs. Grace Lindsay | |
| | | | | ADDRESS
(Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO
Coronary Thrombosis
(B) DUE TO
Hypertensive Cardiovascular Disease
(C) DUE TO
Disease of Gen. Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
Instant
4-17-64
4-17-64 | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-17-1964 to 10-23-1967, that (I) (we) last saw the deceased alive on 9-8-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Robert H. Siver | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10-24-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Robert H. Siver | | 23D. ADDRESS
M.D. 3105 N. Charles St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/25/1967 | | 24C. NAME OF CEMETERY or CREMATORY
Grace Methodist | |
| 24D. LOCATION
Upperco, | | 24E. LOCATION (City, town, or county) (State)
Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|---|--|--|
| BIRTH NO. 67 10149 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10149 | |
| M.E. CASE NO. 6-355 | | | | | |
| 1. NAME OF DECEASED
(Type or Print) GODMAN, VIOLET V. | | | 2. DATE AND HOUR OF DEATH
October 23, 1967 10³⁰ a. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
00 447 North Kenwood Avenue
Baltimore, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 53-00
D. STREET ADDRESS (If rural, give location)
1700 Summit Avenue 21237 | | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
Dec. 28, 1906 | 9. AGE (In years last birthday)
60 yrs. | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY
at home | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
Raymond Sullivan | | |
| 14. MOTHER'S MAIDEN NAME
Ida Mae Mantel | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | |
| 16. SOCIAL SECURITY NO.
220-18-7263 | | | 17. INFORMANT
Edgar W. Godman, husband, above | | |
| 18. 472X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
cardio-pul-vascular disease
INTERVAL BETWEEN ONSET AND DEATH
rd 3 yrs | | | (A) DUE TO | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
obesity, hypertension, generalized arteriosclerosis, acute myocardial insufficiency | | | (C) DUE TO | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 9 19 67 to Oct 23 19 67 , that (I) (we) last saw the deceased alive on Oct 23 19 67 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
LC Dobihal | | | | 23B. DATE SIGNED
10/24/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Louis C. Dobihal | | | | 23D. ADDRESS
447 N. Kenwood Avenue | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/27/67 | | 24C. NAME of CEMETERY or CREMATORY
Woodlawn Cemetery | |
| 24D. LOCATION
Balto., Md. | | 25A. DATE RECEIVED BY HEALTH DEPT.
Oct 25 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Talbot | | 25C. FUNERAL DIRECTOR
Schimunek Funeral Home | | ADDRESS
3331 Brehms Lane #13 | |

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

2. The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

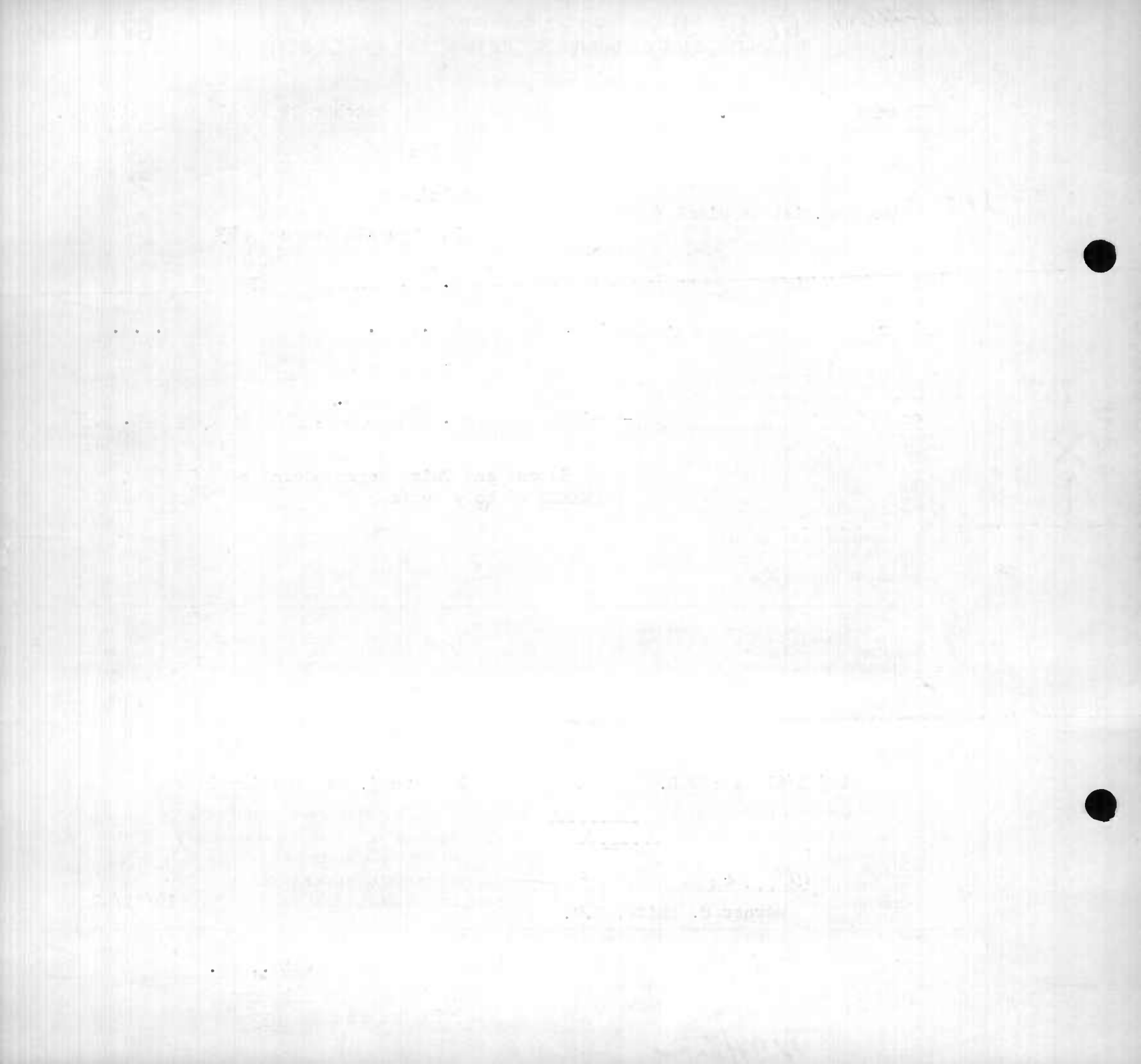
3. The third part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

4. The fourth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

5. The fifth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

| BIRTH NO. | | 67 10150 | | BALTIMORE CITY HEALTH DEPARTMENT | | 67 10150 | |
|--|-------------------------|--|---|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
EDWARD F. HILL | | | | 2. DATE AND HOUR PRONOUNCED DEAD
October 21, 1967 11:00 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

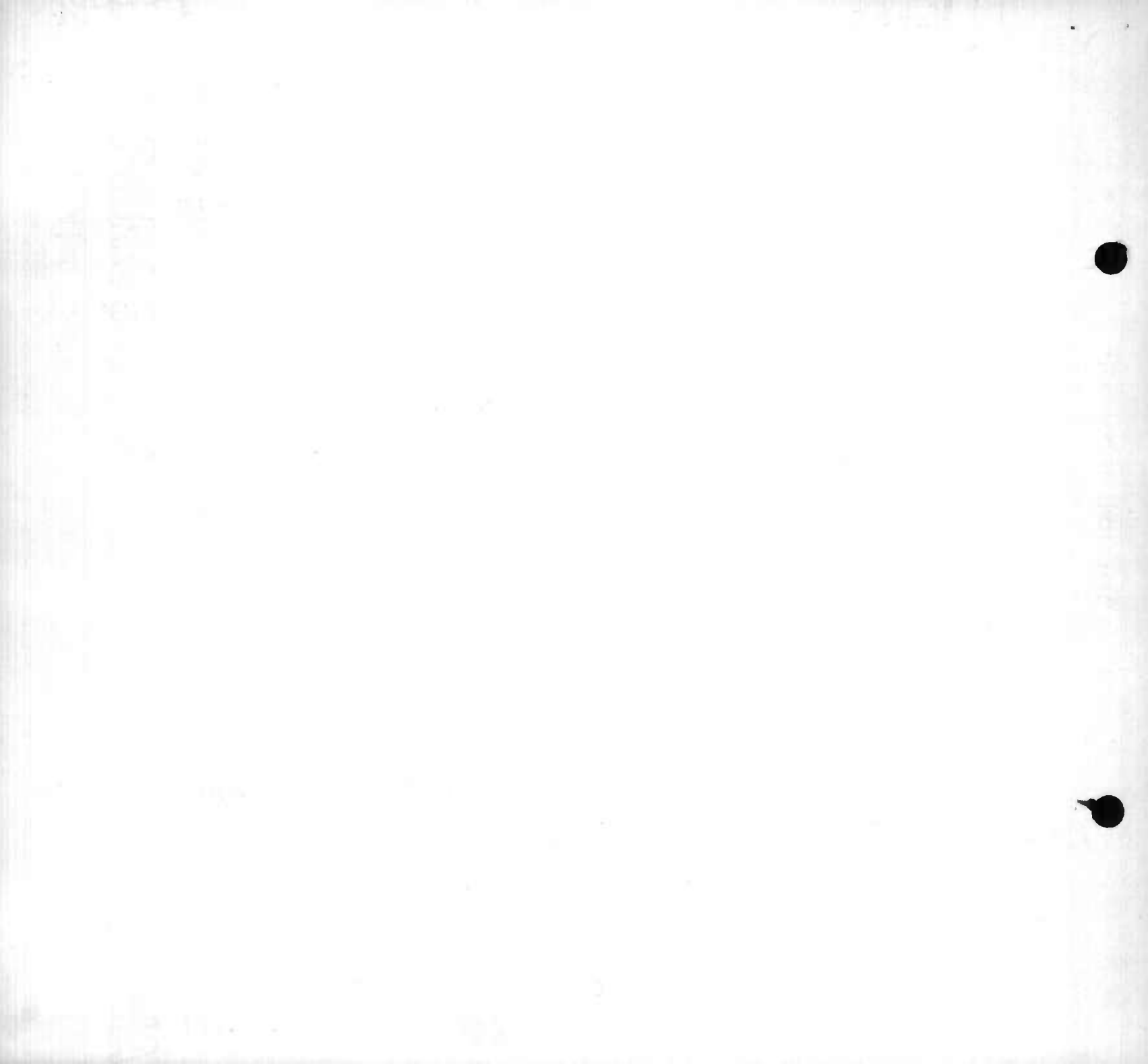
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Union Memorial Hospital (DOA) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3740 Lyndale Avenue #13 | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Sept. 12, 1910 | 9. AGE (in years last birthday)
57 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Driver | | 10B. KIND OF BUSINESS OR INDUSTRY
Eckels Ice Cream | | 11. BIRTHPLACE (State or foreign country)
Balto., Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Clarence Hill | | | | 14. MOTHER'S MAIDEN NAME
Violette Hobbs | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
yes WWII | | 16. SOCIAL SECURITY NO.
217-07-6598 | | 17. INFORMANT
Dght. Mrs. Edna Cator, 3410 Lyndale Ave. #13 | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
E916.0 I Second and Third Degree Burns of 90% XXXXX of body surface
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(A) Second and Third Degree Burns of 90% XXXXX of body surface
(B) DUE TO
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
3740 Lyndale Avenue 26-03 | | | |
| 21D. TIME OF INJURY (APPROX.)
10/21/67 10:30 P.M. | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Subj. was smoking in bed | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Werner U. Spitz, M.D. | | M.D.
Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
10/22/67 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
10/25/67 | | 23C. NAME of CEMETERY or CREMATORY
Baltimore National Cemetery Balto., Md. | | 23D. LOCATION (City, town, or county) (State) | |
| 24A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 24B. NAME OF REGISTRAR
Robert E. Faltys | | 24C. FUNERAL DIRECTOR
Schimunek Funeral Home | | ADDRESS
3331 Brehms Lane #13 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

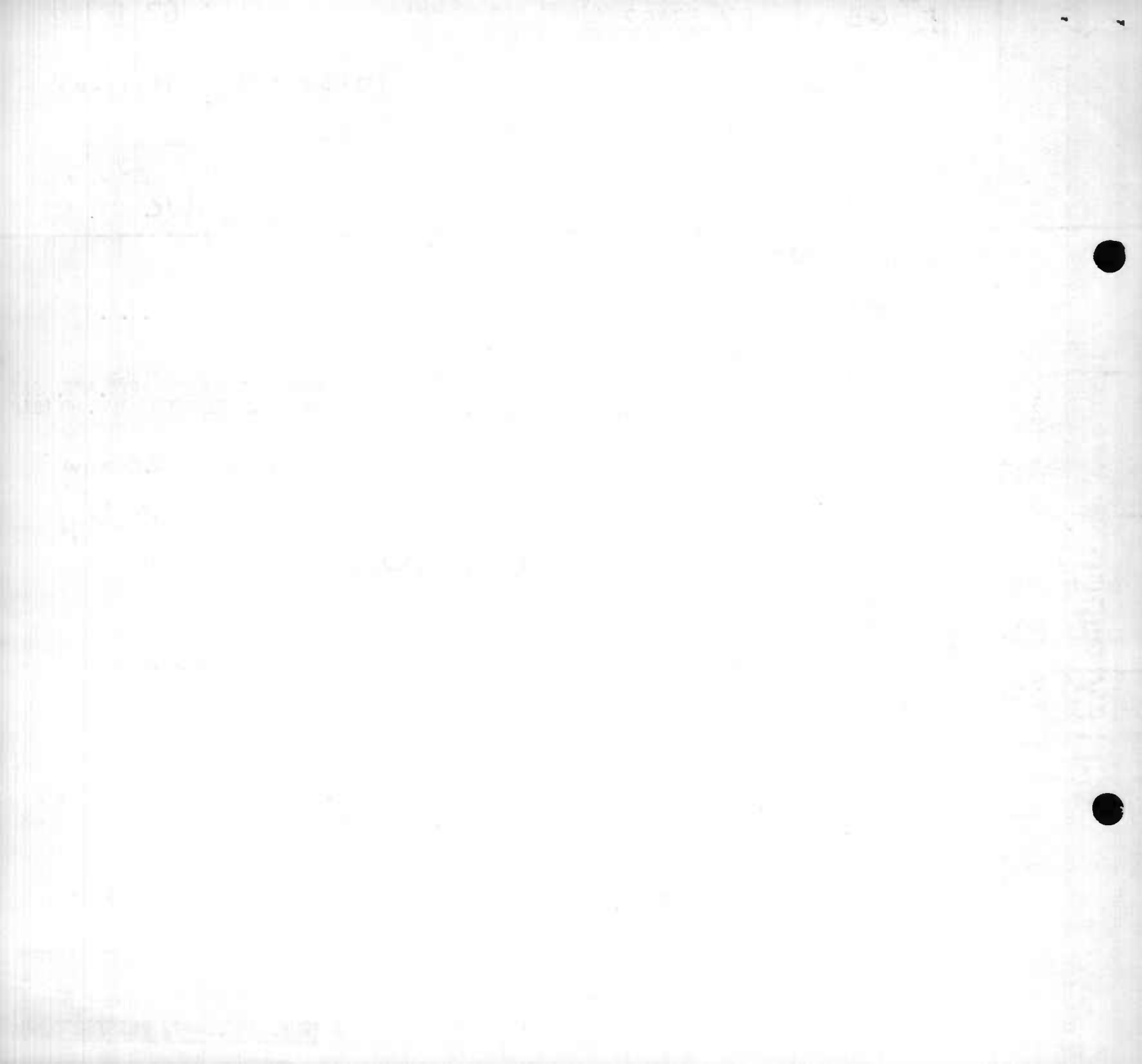
| | | | | | | | |
|---|-------------------------|---|------------------|--|-----------------------|---|-----------------------|
| BIRTH NO. G-521 | | 67 10151 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10151 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) SARAH GINSBERG | | | | OCTOBER 18, 1967 5 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3710 KINGSWOOD SQUARE | | | | A. STATE MARYLAND
B. COUNTY BALTIMORE | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
27-20 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
3710 KINGSWOOD SQUARE #21215 | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH | 9. AGE (In years last birthday)
91 | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
RUSSIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
EDWARD GINSBERG | | | | 14. MOTHER'S MAIDEN NAME
ROSE ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NO | | 17. INFORMANT ADDRESS
MR. MANUEL GINSBERG, 3710 KINGSWOOD SQUARE #15 | | | |
| 18. 332X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
anticoagulant thrombosis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
severe coronary arteriosclerosis | | | | CAUSE OF DEATH
(A) anticoagulant thrombosis
(B) severe coronary arteriosclerosis
(C) | | | |
| INTERVAL BETWEEN ONSET AND DEATH
48 hrs. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
10/18/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1945 to 10/18/67 that (I) (we) last saw the deceased alive on 10/18/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Milton Kirsch | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/18/67 | |
| 23C. PHYSICIAN'S NAME (Type)
MILTON KIRSCH | | | | 23D. ADDRESS
M.D. 4000 W. NORTHERN PARKWAY | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-22-67 | | 24C. NAME of CEMETERY or CREMATORY
AGUDAS ACHIM ANSHE SFARD | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|--|--|--|--|---|------------------------------|
| F-630 | | 67 10152 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10152 | |
| BIRTH NO. | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) ALBERT FREED | | | | 2. DATE AND HOUR OF DEATH
10:37 A.M. 10/18/67 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Sinai Hospital of Balto. | | | | A. STATE
MARYLAND | | | |
| (If not in hospital or institution, give street address or location) | | | | B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
1190 W. BELVEDERE AVE. APT. 513 | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED , NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
7/11/06 | 9. AGE (In years last birthday)
61 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MERCHANT | | 10B. KIND OF BUSINESS OR INDUSTRY
RETAIL | | 11. BIRTHPLACE (State or foreign country)
POLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
AARON GERSHON FREED | | | | 14. MOTHER'S MAIDEN NAME
LEAH BLUMBERG | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
218-32-3375 | | 17. INFORMANT
MRS. RUTH FREED, 1190 W. BELVEDERE AVE. #21210 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
VENTRICULAR FIBRILLATION | | | | INTERVAL BETWEEN ONSET AND DEATH
20 min | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
MYOCARDIAL INFARCTION | | | | 38 days | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
A. S. C. V. D | | | | ? | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>Sept 10</u> 19 <u>67</u> to <u>Oct. 18</u> 19 <u>67</u> , that (I) <u>we</u> last saw the deceased alive on <u>Oct 18</u> 19 <u>67</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
A. F. Wolf | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/18/67 | |
| 23C. PHYSICIAN'S NAME (Type)
ALAN F. WOLF | | | | 23D. ADDRESS
c/o Sinai Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-22-67 | | 24C. NAME of CEMETERY or CREMATORY
BETH YEHUDA ANSHE KURLANDER | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. | | ADDRESS
6010 REISTERSTOWN RD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|-------------------------|---|--------------------------------------|---|---|
| BIRTH NO. C-455 67 10153 | | CERTIFICATE OF DEATH | | 67 10153 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MARION R. COLEMAN | | 2. DATE AND HOUR OF DEATH
10/19/67 5 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY 15-10 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
3801 BELLE AVE 00 | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| | | D. STREET ADDRESS (If rural, give location)
3801 Belle Ave | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Single | 8. DATE OF BIRTH
1-14-1899 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY
at Home | | 11. BIRTHPLACE (State or foreign country)
Lithuania | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Mayer J. Coleman | | 14. MOTHER'S MAIDEN NAME
Anna Mondelle | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-10-3992 | | 17. INFORMANT ADDRESS
Miss Aba Coleman - 3801 Belle Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
331X I | | CAUSE OF DEATH
(A) CEREBROVASCULAR ACCIDENT
DUE TO
(B) ARTERIOSCLEROSIS
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
3 DAYS
YEARS | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1964 to 10/19 19 67 , that (I) (was) lost saw the deceased alive on 10/19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Morton M. Mower | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/19/67 | |
| 23C. PHYSICIAN'S NAME (Type)
MORTON M. MOWER | | 23D. ADDRESS
200 W. COLDSRING LANE BALTO. MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Oct 22/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Morgan Abraham Reedale, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
Sal Johnson & Son Inc - 6010 Reister Rd | |

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Main body of handwritten text, appearing to be a list or series of entries.

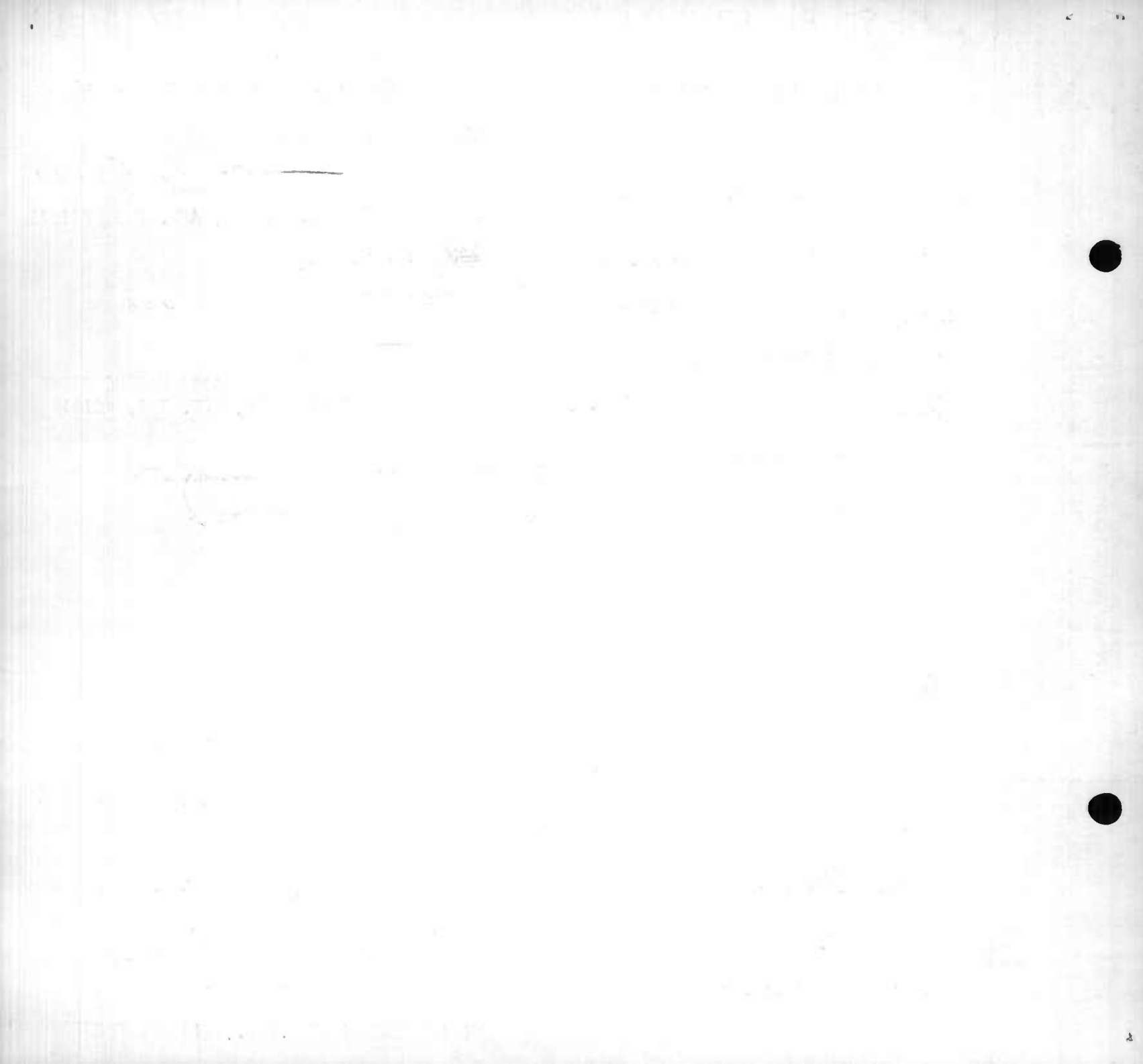
Handwritten text in the middle section, possibly a continuation of the list.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

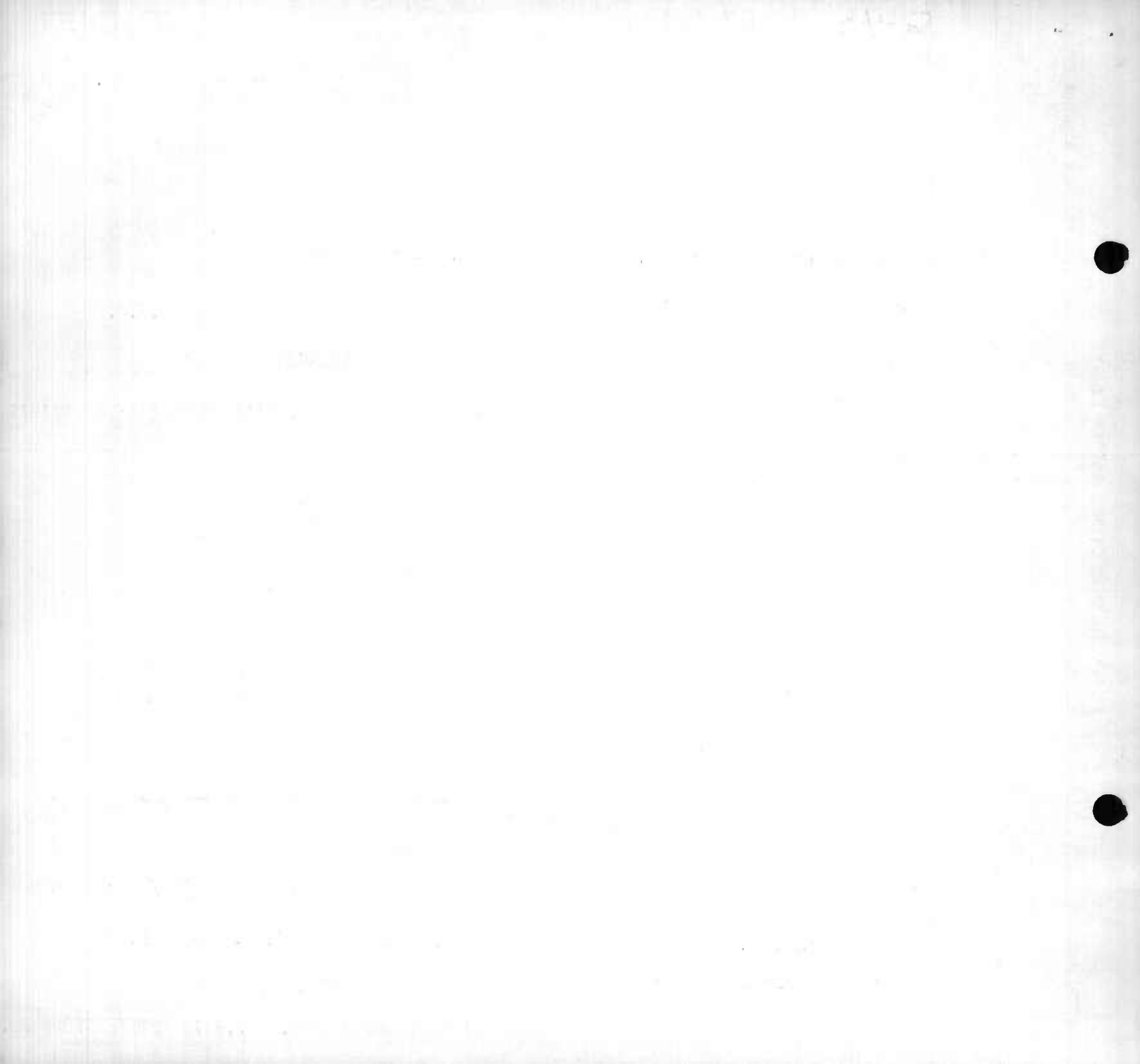
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|---|----------------------|---|--|---|---|
| BIRTH NO. K-521 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10154 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Koenigsberg, Robert | | 2. DATE AND HOUR OF DEATH
October 19, 1967 12:40 AM | |
| 3. PLACE OF DEATH BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore Co | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore City County 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
42 Sinai Hospital of Baltimore, Inc. | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location)
6900 Marsue Dr., APT. T 3 #21215 | |
| 5. SEX
M. | 6. RACE
W. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed. | 8. DATE OF BIRTH
July 18, 1902 | 9. AGE (In years lost birthday)
65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Employed as Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY
Package Liquors | | 11. BIRTHPLACE (State or foreign country)
MARYLAND - BALTIMORE | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
LATE SAMUEL KOENIGSBERG | | 14. MOTHER'S MAIDEN NAME
SADIE MARKEIN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
XXXXXX | | 16. SOCIAL SECURITY NO.
213-21-7604A | | 17. INFORMANT
MISS BARBARA KOENIGSBERG, APT. T 3, #21215 | |
| 18. 199-2-1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Carcinoma - Primary site Unknown Metastases to Brain and Lungs | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
4 months | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
None | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from October 18, 1967 to October 19, 1967 , that (I) (we) last saw the deceased alive on October 18, 1967 - 11:15 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Mayer Heller | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
October 19, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
I. MAYER HELLER | | 23D. ADDRESS
Sina: Hospital of Baltimore, Inc. Belvedere at Greenspring | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-22-67 | | 24C. NAME OF CEMETERY or CREMATORY
ARLINGTON CEMETERY | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD | | 25D. ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

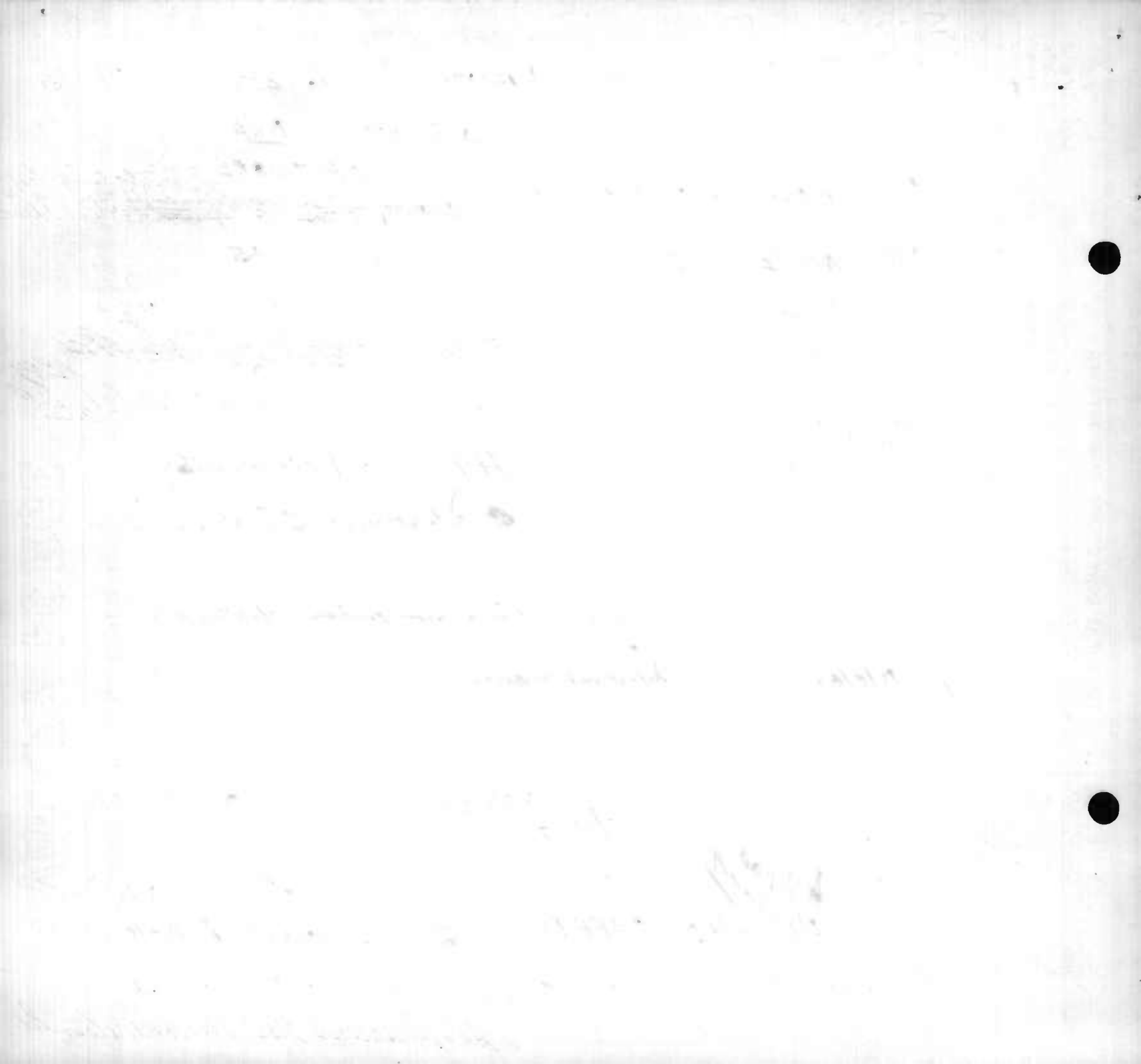
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|--|-------------------------|--|--|--|---|--|------------------------------|
| BIRTH NO. G-426 | | 67 10155 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10155 | |
| CERTIFICATE OF DEATH | | | | | | | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) DORA GELWASSER | | | | 10-19-67 2.15 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL
33 | | | | A. STATE MARYLAND
B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
3118 TIOGA PARKWAY | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
9-20-98 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | 11. BIRTHPLACE (State or foreign country)
POLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
DAVID SILVER | | | 14. MOTHER'S MAIDEN NAME
PEARL SILVER | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MR. LOUIS GELWASSER, 3118 TIOGA PARKWAY #21215 | | | ADDRESS |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CARCINOMA - METASTATIC | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 28 19 67 to Oct 19 19 67 , that (I) (we) last saw the deceased alive on Oct 19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Ron E. Smith | | | | | | 23B. DATE SIGNED
Oct 19, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
RON E. SMITH | | | | | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-22-67 | 24C. NAME OF CEMETERY or CREMATORY
BETH TFILOH | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD. | | | |



FUNERAL DIRECTOR: IMPORTANT

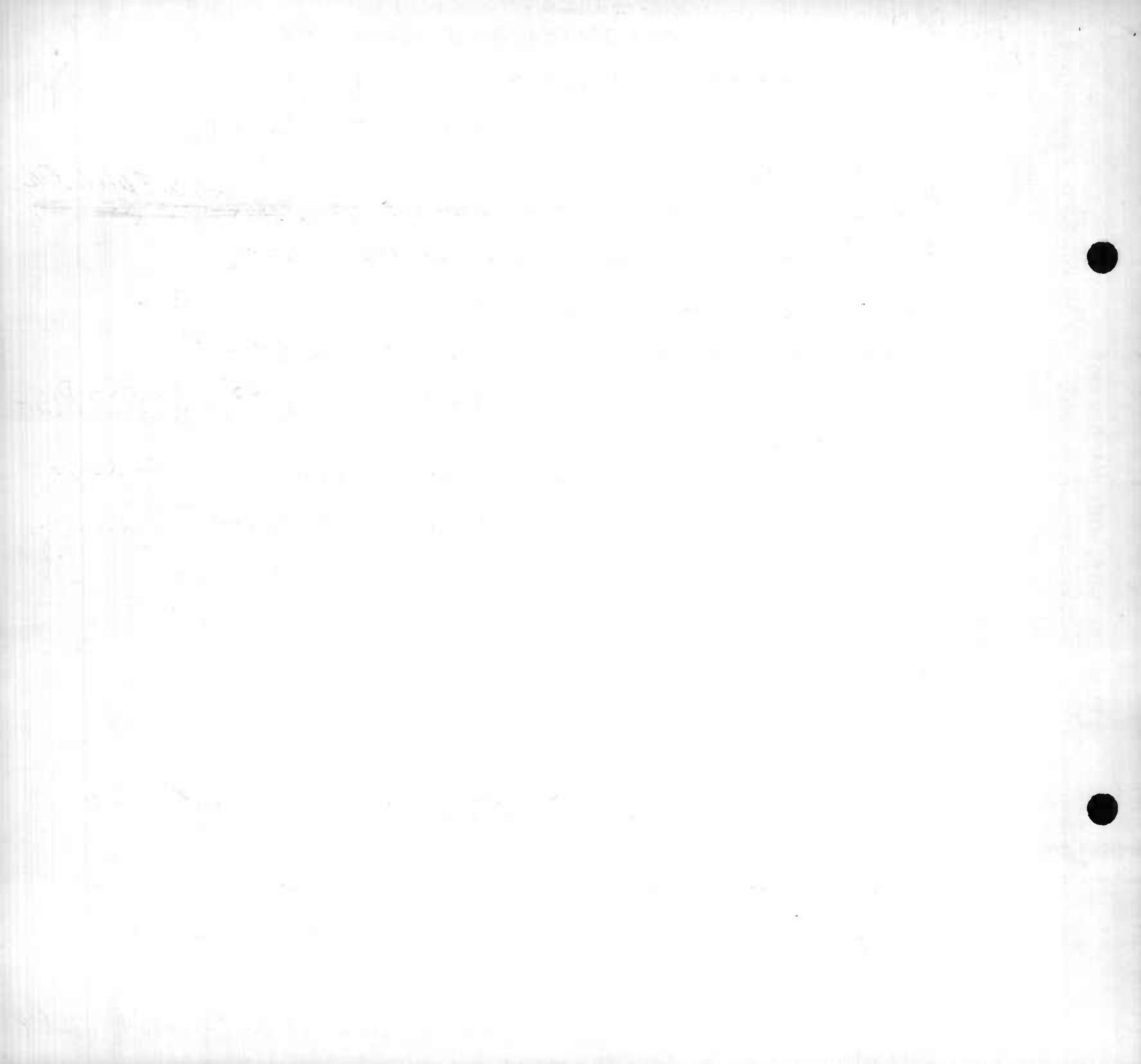
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 67 10156 | |
|---|--|--|--|--|--|
| S-550 | | 67 10156 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| | | | | SIMON, ROBERT MALTON | |
| 2. DATE AND HOUR OF DEATH | | 10.45 PM 10/21/67 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| SINAI HOSPITAL OF BALTIMORE | | MARYLAND CISA 27-17 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Male | WHITE | Single | June 5, 1912 | 55 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| Clerk | Grocery Store | Baltimore, Md. | U.S.A. | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Samuel Simon | | Jennie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Mrs. Mollie Townsend - 3712 Baltimore Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 570.5 I | | Aspiration pneumonia | | | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | Intestinal obstruction | | | |
| II | | Generalized muscular dystrophy | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 10/10/67 | Intestinal obstruction | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/29/67 to Oct-21st-67 that (I) (we) last saw the deceased alive on 10/21/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 10/21 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| ARSHAD SAEED | | Sinai Hospital Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 10/22/67 | St. Francis Cemetery | Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| OCT 25 1967 | Robert E. Tardone | Sol. Lewin & Son | | 6010 Rustic Road | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

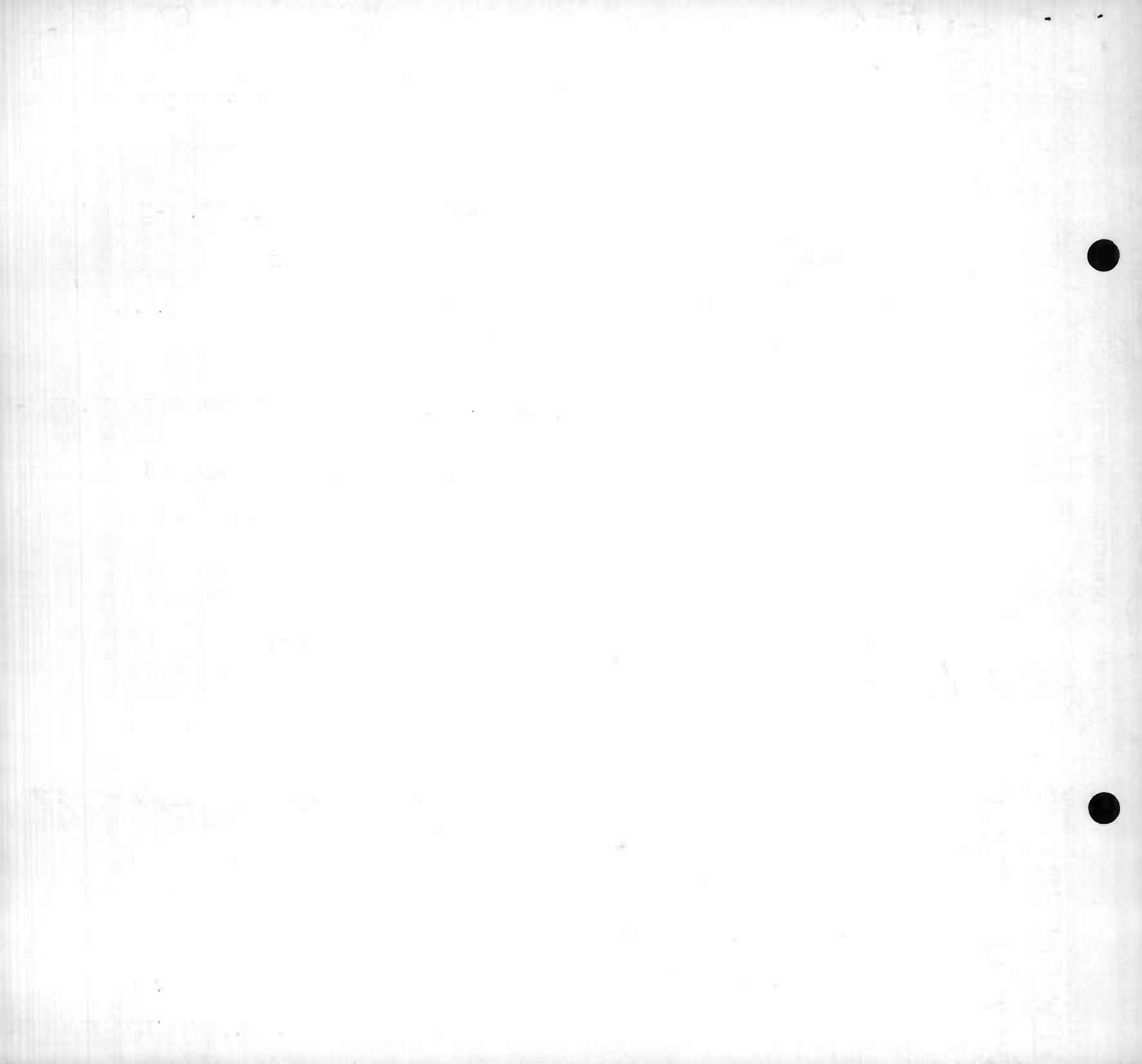
| | | | |
|---|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10157 | |
| BIRTH NO. 60 | | 67 10157 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) SARAH LESSER | | 2. DATE AND HOUR OF DEATH
10-21-67 2 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Leindale Aged Home
Greenspring & W. Belvedere Ave | | A. STATE Md B. COUNTY Baltimore 28-31 | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| 5. SEX Female RACE White | | D. STREET ADDRESS (If rural, give location) 6512 Everly Dr | |
| 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | | 8. DATE OF BIRTH 7-16-1886 9. AGE (In years last birthday) 81 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Seamstress | | 11. BIRTHPLACE (State or foreign country)
Kiev (Russia) | |
| 10B. KIND OF BUSINESS OR INDUSTRY
Cloak factory | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Abraham Klavansky | | 14. MOTHER'S MAIDEN NAME
Lena Abraham? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mr. Harry Lesser | | ADDRESS
6512 Everly Dr. Apt 301 Baltimore 21215 | |
| 18. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Branchopneumonia
INTERVAL BETWEEN ONSET AND DEATH 2 days | | (A) DUE TO | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ASCVD post CVA
INTERVAL BETWEEN ONSET AND DEATH 7 months | | (B) DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II | | (C) DUE TO | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 11/54 19 to Oct 21/67 19, that (I) (we) lost saw the deceased alive on Oct 21/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Jose Ardair | | 23B. DATE SIGNED
10-21-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Jose ARDAIR | | 23D. ADDRESS
5912 Cross Country Blvd. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Oct 22/67 | |
| 24C. NAME OF CEMETERY or CREMATORY
Beth Hamedash Hsg | | 24D. LOCATION (City, town, or county) (State)
Rosedale, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
Sol Leunson & Sons | | ADDRESS
6010 Reet Rd | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10158 | |
|---|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. F-635 67 10158 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) FRIEDMAN SAMUEL | | 2. DATE AND HOUR OF DEATH
10 - 22 - 67 12.30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSPITAL OF BALTIMORE | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
6007 PARK HEIGHTS AVE., APT. B-2 #21215 | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
9/25/94 | 9. AGE (In years last birthday)
73 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY
PLUMBING SUPPLIES | | 11. BIRTHPLACE (State or foreign country)
RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
NATHAN FRIEDMAN | | 14. MOTHER'S MAIDEN NAME
MARISHA ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
218-32-1358 | | 17. INFORMANT
MRS. ROSE FRIEDMAN, 6007 PARK HIGHTS AVE. APT B-2 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Heart failure second to liver Cirrhosis | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
9-22-67 till 10-22-67 | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Exploratory laparotomy | | | | | |
| 19A. DATE OF OPERATION
10/16/1967 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/22 1967 to 10/22 1967 , that (I) (we) last saw the deceased alive on 10/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
ReSpanos | | | | 23B. DATE SIGNED
10-22-67 | |
| 23C. PHYSICIAN'S NAME (Type)
PANAYIOTIS C. SPANOS | | 23D. ADDRESS
SINAI HOSPITAL OF BALTIMORE MARYLAND | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-23-67 | | 24C. NAME OF CEMETERY or CREMATORY
BOBROISKER BENEFICIAL CIRCLE | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Feltner | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD. | |

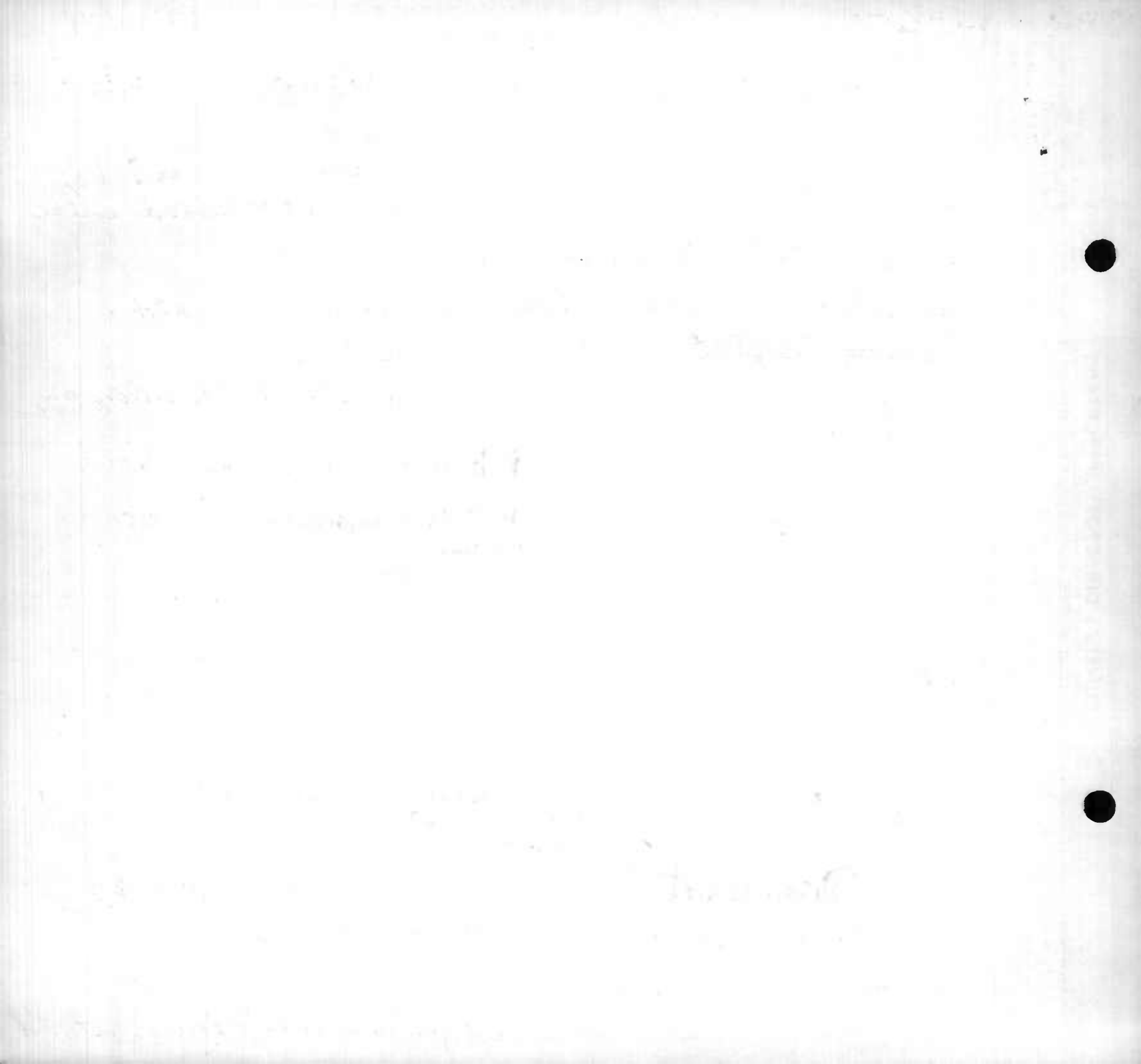


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10159 | |
| BIRTH NO. 655 | | 67 10159 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Lem Sherman | | 2. DATE AND HOUR OF DEATH
10/21/67 6:35 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
42 Sinai Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
Greenpring Ave 1 W. Belvedere Ave | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
Widowed, Divorced (specify) | 8. DATE OF BIRTH
Nov 3, 1884 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
finisher | | 10B. KIND OF BUSINESS OR INDUSTRY
clothing factory | 9. AGE (in years last birthday)
82 |
| 11. BIRTHPLACE (State or foreign country)
Russia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Samuel Helfand | | 14. MOTHER'S MAIDEN NAME
Fannie? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Raymond Helfand | | ADDRESS
7402 Doyman Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
H20.1 I | | CAUSE OF DEATH
(A) DUE TO Prob myocardial infarction
(B) DUE TO ASCVD & myocardial
(C) ischemia | |
| INTERVAL BETWEEN ONSET AND DEATH
hours | | years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
10/21/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 10/21 19 67 to 10/21 19 67 , that (1) (we) last saw the deceased alive on 10/21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Susan Logat | | 23B. DATE SIGNED
10/21/67 | |
| 23C. PHYSICIAN'S NAME (Type)
SUSAN LOGAT | | 23D. ADDRESS
SINAI HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Oct 24/67 | |
| 24C. NAME of CEMETERY or CREMATORY
Brown Island | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Faldut | |
| 25C. FUNERAL DIRECTOR
Sol Sherman | | ADDRESS
6000 Reister Rd | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10160 | |
|--|---------------------|--|--|--|--|
| BIRTH NO. 67 10160 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Lacher, Laura Pauline | | 2. DATE AND HOUR OF DEATH
10/23 / 67 8 05 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Union Memorial Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location)
3408 Oakenshaw Place | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH
1/24/84 | 9. AGE (In years last birthday)
83 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOME MAKER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Henry Lacher | | 14. MOTHER'S MAIDEN NAME
Anna Schulz | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-46-9003-J1 | | 17. INFORMANT
MISS ELIZABETH LACHER
3408 OAKENSHAW PLACE | |
| 18. 570.5 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO
Intestinal Obstruction | | 3 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
Cause Unknown | | | |
| (C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/20 / 1967 to 10/23 / 1967 , that (I) (we) last saw the deceased alive on 10/23 / 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dr. Harry F. Holcomb Jr. | | | | 23B. DATE SIGNED
10/23 / 67 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. HARRY F. HOLCOMB JR. | | | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/27/67 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park | |
| 24D. LOCATION
Baltimore | | 24E. STATE
Md. | | 24F. ADDRESS
4905 York Rd. Balto. 12, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, MD | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | |

James Jackson

James Memorial Hospital



F W

Henry Jackson

10/23/83

Dr. Thomas

3008 Oakwood Drive

1/24/84 83

MD

1/24

James Jackson

Dr. Thomas Jackson

James Jackson

No

10/23/83 10/23/83 10/23/83 10/23/83 10/23/83 10/23/83 10/23/83 10/23/83 10/23/83 10/23/83

James Jackson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | 67 10161 |
|---|---------------------|---|-----------------------------------|---|---|
| BIRTH NO. | | 67 10161 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>MARY C. MURRAY</i> | | 2. DATE AND HOUR OF DEATH
<i>10/22/67 8:00 AM</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Bon Secours Hospital</i> | | A. STATE <i>MD.</i>
B. COUNTY <i>HOWARD Co</i> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Ellicott City 63-00</i> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<i>310 GAWAID DRIVE</i> | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>C</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>WIDOWED</i> | 8. DATE OF BIRTH
<i>2-8-97</i> | 9. AGE (In years
last birthday)
<i>70</i> | 10. Under 1 Yr.
Months Days
11. Under 24 Hrs.
Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>MARYLAND</i> | |
| 13. FATHER'S NAME
<i>George CURRIE</i> | | 14. MOTHER'S MAIDEN NAME
<i>McAuliffe</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<i>216-54-6948</i> | | 17. INFORMANT
<i>CHART</i> | |
| 18. <i>133.11</i>
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.) | | CAUSE OF DEATH
(A) <i>Cardiac arrest</i>
DUE TO
(B) <i>Ventricular fibrillation</i>
DUE TO
(C) <i>Arterio sclerosis cardiovascular</i>
<i>disease</i> | | INTERVAL BETWEEN
ONSET AND DEATH
<i>minutes</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | | 21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME
OF INJURY
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While
At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-25</i> 19 <i>67</i> to <i>10-22</i> 19 <i>67</i> ,
that (I) (we) last saw the deceased alive on <i>10/22</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Octavio A. Ruiz</i> | | | | 23B. DATE SIGNED
<i>10-22-67</i> | |
| 23C. PHYSICIAN'S
NAME (Type)
<i>Octavio A. Ruiz</i> | | | | 23D. ADDRESS
<i>Bon Secours Hospital</i> | |
| 24A. BURIAL CREMATION,
REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>10-25-67</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Baltimore National Cem</i> | |
| 24D. LOCATION
(City, town, or county)
<i>Baltimore</i> | | 24E. STATE
<i>MD.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 25 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fairley</i> | | 25C. FUNERAL DIRECTOR
<i>Farley-CAVANAUGH</i> | |
| | | | | ADDRESS
<i>6601
FREDERICK Rd</i> | |

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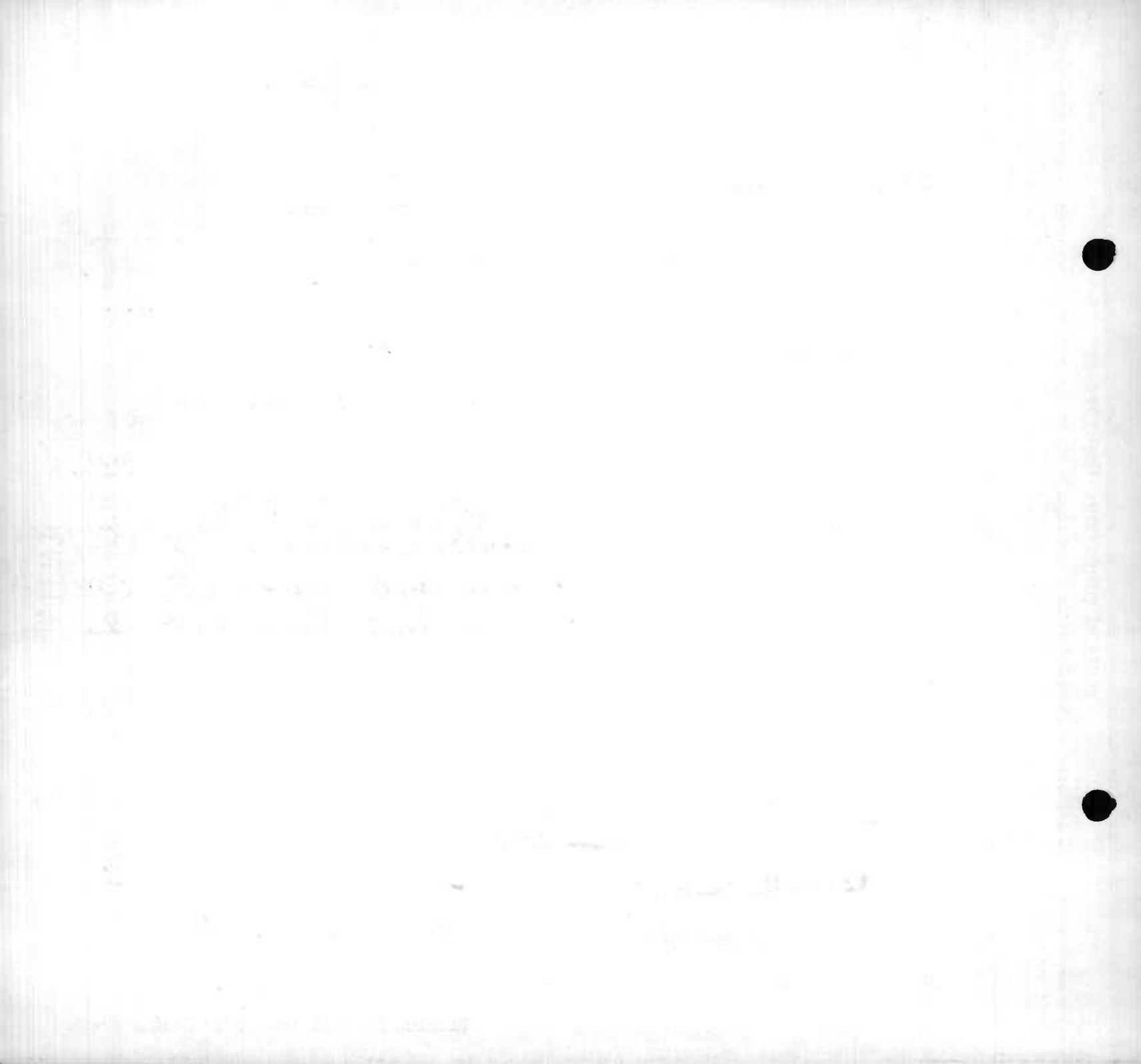
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------|--|------------------|---|---|
| BIRTH NO.
67 10162 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10162 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Lora Mae Hobbs | | October 20, 1967 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital at institution, give street address or location) | | A. STATE
Maryland | | | |
| 31 Baltimore City Hospitals | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 27-01 | | | |
| | | D. STREET ADDRESS (If rural, give location)
2823 Pelham Ave. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. Under 1 Yr.
Months Days Hours Min. |
| Female | White | Widowed | May 16, 1904 | 63 | |
| 10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| At home | | | | Alabama | |
| 12. CITIZEN OF
WHAT COUNTRY? | | U.S.A. | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| William Pugh | | Lora Gorham | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL
SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | Leroy Hobbs 576 Welbrook Road | |
| 18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN
ONSET AND DEATH | |
| 420.1 I | | Myocardial Infarction | | 24 hrs. | |
| ANTECEDENT CAUSES | | Coronary Thrombosis | | 2 yrs. | |
| DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last. | | Hypertensive C-V Dis. | | 1 month | |
| II | | Arteriosclerosis | | 1 month | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | Acuter - Septal Infarction | | | |
| complete Bundle Branch Block | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | | 21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME
OF INJURY
(APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 10/17 1964 to 10/19 1967,
that (I) (we) last saw the deceased alive on 10/19 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Kenneth Krulevitz | | | | 10/21/67 | |
| 23C. PHYSICIAN'S
NAME (Type) | | 23D. ADDRESS | | | |
| Kenneth Krulevitz | | 7538 Holabird Ave. | | Baltimore 21222 | |
| 24A. BURIAL CREMATION,
REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 10/23/67 | | Oak Lawn Cemetery | |
| | | | | Colgate, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| OCT 25 1967 | | Robert E. Farber | | Ullrich Funeral Home 4210 Belair Road. | |



D-100

67 10163

BALTIMORE CITY HEALTH DEPARTMENT

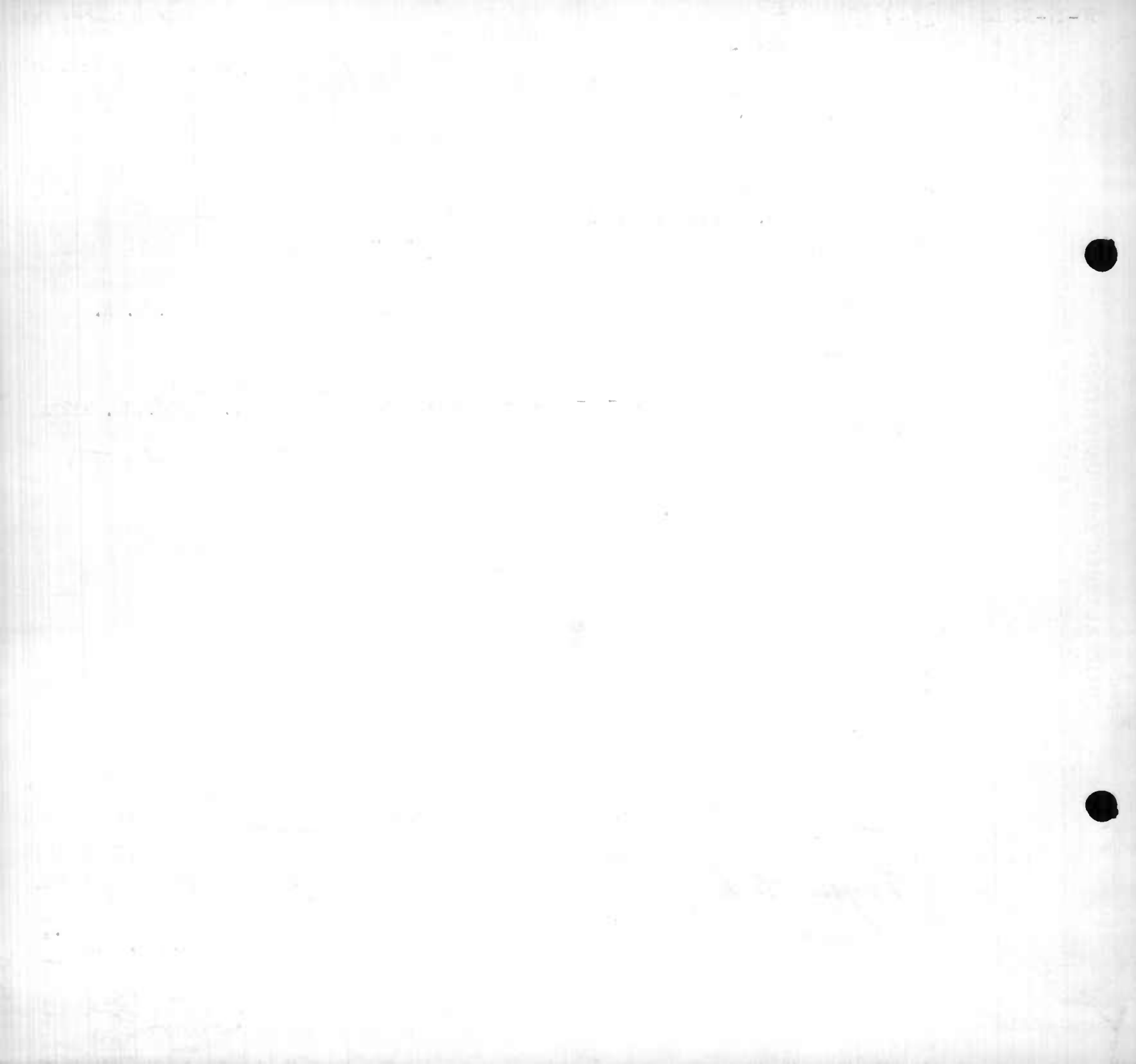
CERTIFICATE OF DEATH

Registered No. 67 10163

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

| | | | | | | | |
|---|-------------------------|--|------------------------------------|--|--|--|---|
| BIRTH NO. D-100 | | 67 10163 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10163 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) MADINE VIRGINIA DUFF VIRGINIA DUFF | | | | 10/20/67 10-20-67 6:00 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | | | A. STATE MARYLAND
B. COUNTY X | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
1315 RAYLEIGH WAY 21224 | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
6-16-06 | 9. AGE (In years last birthday)
61 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
DOMESTIC | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 13. FATHER'S NAME
ALBERT DUFF | | | | 14. MOTHER'S MAIDEN NAME
CORDIA BROTHERTON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO. | | | | 16. SOCIAL SECURITY NO.
236-50-5051 | | 17. INFORMANT ADDRESS
BALTIMORE CITY HOSPITALS
RECORDS: 4940 EASTERN AVE., BALTO., MD. 21224 | |
| 18. I 153.8 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Carcinoma of colon = metastases
(B) 4 months
(C) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/27 19 67 to 10/20 19 67 , that (I) (we) last saw the deceased alive on 10/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Benjamin Lechner, MD. | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
Oct 20, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
BENJAMIN LECHNER, MD
Benjamin Lechner | | | | 23D. ADDRESS BALTIMORE CITY HOSPITALS
4940 EASTERN AVE., BALTO., MD. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
10/21/67 | | 24C. NAME OF CEMETERY or CREMATORY
Glen Haven Cemetery | | 24D. LOCATION (City, town, or county) (State)
Glen Burnie, Md. | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Archibald Funeral Home, Inc. | | 25D. ADDRESS
Laurel, Md. | |



L-236

67 10164 BALTIMORE CITY HEALTH DEPARTMENT

67 10164

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN ELASTER

2. DATE AND HOUR PRONOUNCED DEAD

October 23, 1967 11:55 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General Hospital

D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

637 Wyeth Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

11-2-24

9. AGE (In years last birthday)

42

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Asst Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Scrap metal

11. BIRTHPLACE (State or foreign country)

Tennessee

12. CITIZEN OF WHAT COUNTRY

USA

13. FATHER'S NAME

Low Laster

14. MOTHER'S MAIDEN NAME

Rose Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

-

17. INFORMANT

Ruth Laster

ADDRESS

- Blount

18A.

E 902.13

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple traumatic injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Factory

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Dupont Co. 2001 Benhill Ave. 25-05

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) (Minute)

10 23 67 11:00

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

Working on trestle when it collapsed

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 23, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

10-27-67

23C. NAME OF CEMETERY or CREMATORY

London Park

23D. LOCATION

Belts

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 25 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

John J. Cowan + Son, Inc.

ADDRESS

Belts

1900

1900

1900

1900

1900

1900

1900

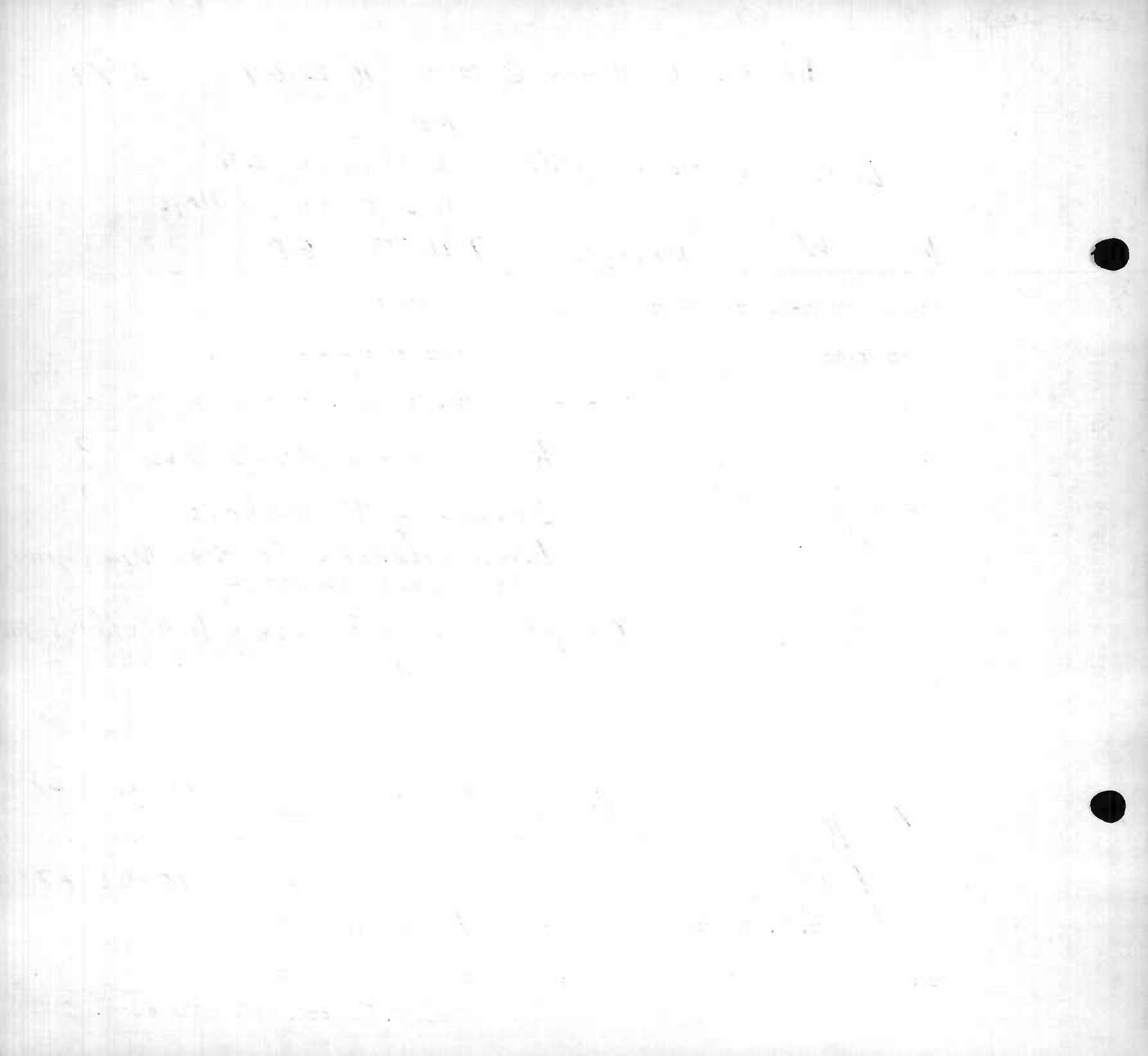
1900

FUNERAL DIRECTOR: IMPORTANT

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| BIRTH NO. 67 10165 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 10165 | | |
|--|---------------------|--|---|---|--|--|---|--|-------------------------|--|
| 1. NAME OF DECEASED
(Type or Print) HAYES, William O. Crouse | | | | 2. DATE AND HOUR OF DEATH
10-22-67 | | 315/p M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
46 Lutheran Hosp of Md. | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 29
D. STREET ADDRESS (If rural, give location) 183 Oakley Village | | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Married | 8. DATE OF BIRTH 98 7-21-1919 | | 9. AGE (In years lost birthday) 16/8 69 | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Kitchen Worker-Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY
Emerson Hotel | | | | | | | |
| 13. FATHER'S NAME
Edgar Hayes | | | | 14. MOTHER'S MAIDEN NAME
Georgeanna - - - | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
213-01-51304 | | 17. INFORMANT
Mrs. Vallie L. Hayes, 183 Oaklee Village | | | | ADDRESS
21229 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Ante Myocardial Infarction | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO
Coronary thrombosis
Arteriosclerotic Cardio. Many years.
Unusual Disease | | | | INTERVAL BETWEEN ONSET AND DEATH
? | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Conjunctive Heart Failure + Ch. Arterial Fibri/lat | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 10-22 19 67 to 10-22 19 67 , that (1) (we) last saw the deceased alive on 16-22 19 67 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
 | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10-22-67 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. R. Druega | | | 23D. ADDRESS
Lutheran Hosp | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/25/67 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park Cemetery | | | 24D. LOCATION (City, town, or county)
Baltimore | | (State)
Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. | | | | ADDRESS
21229 | |



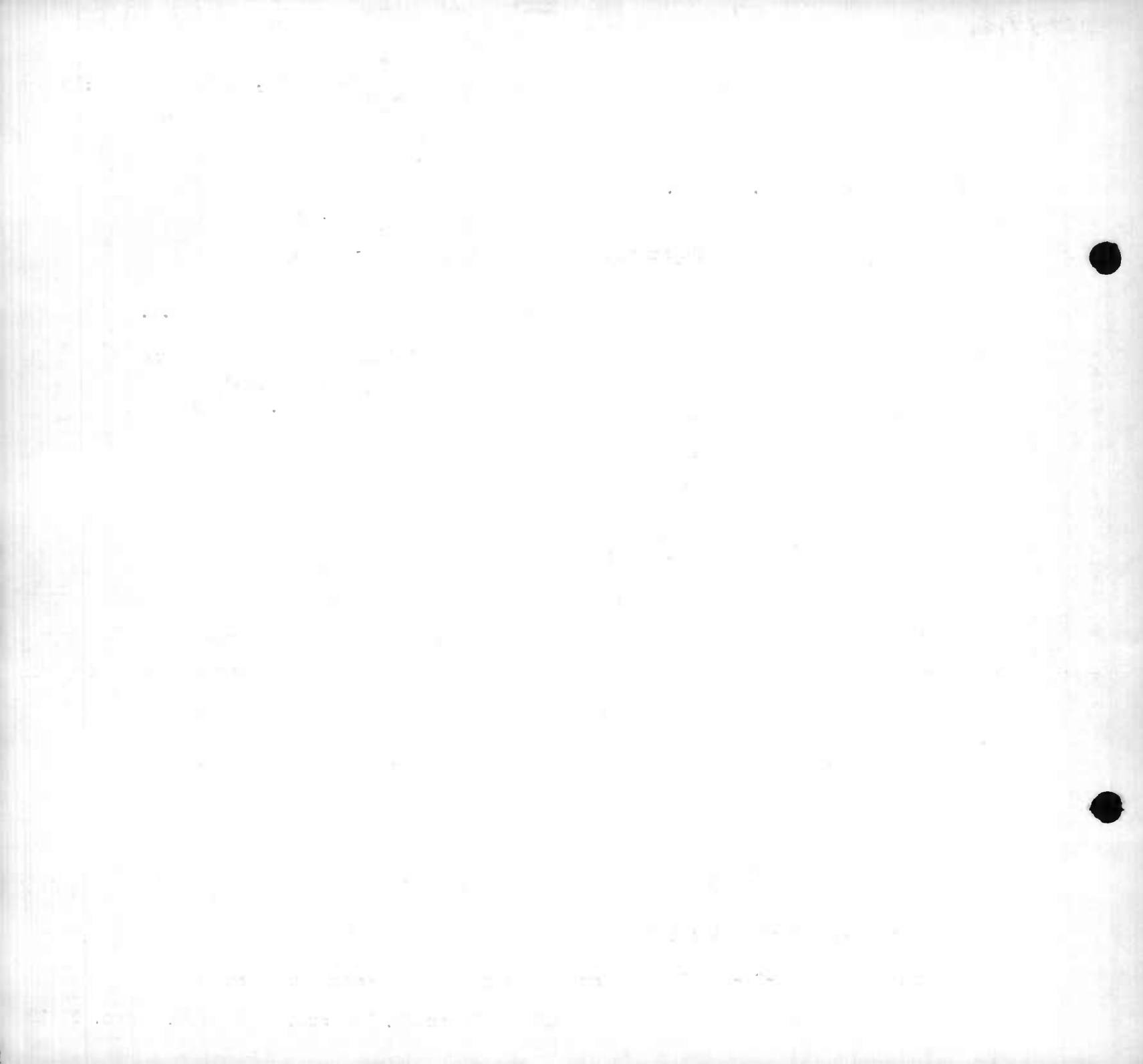
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10166 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10166 | |
|--|--|--|--|---|--|-------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | | |
| (Type or Print) | | | | JAMES B. HOWARD | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 2. DATE AND HOUR OF DEATH | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | 10/21/67 - 1050 P.M. | | | |
| (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| Sinai Hospital | | | | Maryland | | | |
| Belvedere Ave. at Greenspring | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| 42 | | | | Linthicum Heights | | | |
| 901 Lynvue Drive | | | | D. STREET ADDRESS (If rural, give location) | | | |
| 21090 | | | | 9. AGE (In years lost birthday) | | | |
| 10/25/67 | | | | 56 | | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| Engineer (Chief) | | | | Maryland | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Hicks Howard | | | | Daisy Deane | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| No | | | | 212-05-8645 | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| Mrs. Barth Dorothy A. Howard | | | | 901 Lynvue Drive 21090 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | 10/13-10/21/67 | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (APPROX.) | | | |
| 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/13/67 to 10/21/67 | | | | 19 to 19 | | | |
| that (I) (we) last saw the deceased alive on 10/21/67 | | | | 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | | | 23B. DATE, SIGNED | | | |
| Brace B. Ettay, House Staff | | | | 10/21/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Sinai Hospital | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) | | | |
| 24B. DATE | | | | 24C. NAME OF CEMETERY or CREMATORY | | | |
| Burial 10/25/67 | | | | Loudon Park Cemetery | | | |
| 24D. LOCATION (City, town, or county) (State) | | | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| Baltimore Md. | | | | 10/25/67 | | | |
| 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR | | | |
| Robert E. Farber | | | | Howard H. Hubbard | | | |
| 4107 Wilkens Ave. 21229 | | | | 25D. ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10167 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10167 | |
|--|---------|--|---|---|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | Lillian Wehberg | | October 20, 1967 7:10 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | Maryland | | Belt Co. | |
| Bolton Hill Nurs. & Conv. Center | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Lansdowne | |
| D. STREET ADDRESS (If rural, give location) | | | | 208 5th Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| Female | White | Separated | 6/16/84 | 83 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| | | | Maryland | | U.S. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | | |
| George Dowell | | | Nellie Dinsmore | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| | | | | | 1400 Johns Street Bolton Hill & Conv. Center | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I | | | Ca of the Liver | | | | |
| ANTECEDENT CAUSES | | | DUE TO | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. | | | DUE TO | | | | |
| II | | | Fracture of the hip | | | 40 years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Fracture of the hip | | | 25 days | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | no | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | ST. AGNES HOSP. | | ST AGNES HOSP. | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| Sept 25, 1967 | | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | Fell out of bed. | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/11 1967 to 10/20 1967, that (I) (we) last saw the deceased alive on 10/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | | | 23B. DATE SIGNED | |
| K. G. DRITSAS | | | | | | Oct 21, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| K. G. DRITSAS | | | | 6017 ALTA AVE. BALTO, MD 21206 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 10-23-67 | | Loudon Park Cemetery | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| OCT 25 1967 | | Robert E. Taylor | | Howard H. Hubbard, 4107 Wilkens Ave. | | 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|-------------------------------------|---|---|
| 67 10168 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10168 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) LEACH ADA E. | | 2. DATE AND HOUR OF DEATH
October 22, 1967 9:10 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 13-05 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNION MEMORIAL HOSPITAL | | D. STREET ADDRESS (If rural, give location)
629 W. 33rd Street, Balt 11 | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
NEVER MARRIED | 8. DATE OF BIRTH
09-03-81 | 9. AGE (In years last birthday)
86 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MATRON | | 10B. KIND OF BUSINESS OR INDUSTRY
POLICE DEPT. | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY?
AMERICAN | | 13. FATHER'S NAME
CHARLES LEACH ELI F. LEACH | | 14. MOTHER'S MAIDEN NAME
MILINDA GROVES | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKNOWN NO | | 16. SOCIAL SECURITY NO.
216-09-2598 | | 17. INFORMANT ADDRESS
CHARLES LEACH - 731 Colorado Ave, Balt 10 | |
| 18. 331 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Cerebro Vascular Accident
ANTECEDENT CAUSES
Arteriosclerosis
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Cerebro Vascular Accident
DUE TO
(B) Arteriosclerosis
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 2, 1967 to October 22, 1967 , that (I) (we) lost saw the deceased alive on October 22, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
[Signature] | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
October 22, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
MIGUEL SANCHEZ-PALACIOS | | 23D. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Oct 25 1967 | | 24C. NAME of CEMETERY or CREMATORY
DRUID RIDGE CEMETERY | |
| 24D. LOCATION (City, town, or county) (State)
PIKESVILLE Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farber | | 25C. FUNERAL DIRECTOR ADDRESS
BURGEE FUNERAL HOME 3631 FALLS Rd. | |

October 25, 1967

Page 4

MARYLAND

BALTIMORE

634 W 22nd Street, Baltimore

Union Memorial Hospital

F W never married 09-03-81

Maryland Police Dept. VIRGINIA

CHESAPEAKE FARMER'S MARKET GROVES

CHESAPEAKE FARMER'S MARKET - 731 Columbia Ave. Baltimore

Cerebro Vascular Accident

Arteriosclerosis

no

no

October 27, 63
September 5, 63
October 21, 63

W. J. [Signature]

October 25, 1967
X
Union Memorial Hospital

Union Memorial Hospital

BURGESS - NEURAL HYPERTENSION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10169 | |
|---|---------------------|---|---|--|---|
| BIRTH NO. 67 10169 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) GEORGE DINKO | | 2. DATE AND HOUR OF DEATH
October 23, 1967 10:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Lutheran Hospital
46 of Maryland | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
20-03 | | |
| | | | D. STREET ADDRESS (If rural, give location)
2008 Wilkens Ave 21223 | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
3/28/14 | 9. AGE (In years last birthday)
53 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerical | | 10B. KIND OF BUSINESS OR INDUSTRY
Martin Marietta | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | |
| 13. FATHER'S NAME
Andrew Dinko | | | 14. MOTHER'S MAIDEN NAME
Annie Matroka | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-14-8442 | | 17. INFORMANT ADDRESS
Mrs. Kathryn Dinko, 2008 Wilkens Ave. 21223 | |
| 18. 560.41
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. If means the disease, injury or complication which caused death.)
Pneumonia, bacterial
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Plate Atherosclerosis, both lungs
Post-op - Fracture femur Repair?
Splenectomy | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION
10/16/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Shedding Fracture femur | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/11/67 to 10/23 19 67 , that (I) (we) last saw the deceased alive on 10/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Desiderio L. Hebron, Jr. M.D. | | | | 23B. DATE SIGNED
10/23/67 | |
| 23C. PHYSICIAN'S NAME (Type)
DESIDERIO L. HEBRON, JR. | | 23D. ADDRESS
Lutheran Hospital of Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/27/67 | | 24C. NAME OF CEMETERY OR CREMATORY
St. Michaels Ukrainian Cath. | |
| 24D. LOCATION
German Hill Rd., Balto. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
Oct 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |

2-19-48

Dear Mr. [illegible]
[illegible]
[illegible]

Very truly yours,
[illegible]
[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|---|---|---|
| BIRTH NO. 67 10170 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10170 | |
| 1. NAME OF DECEASED
(Type or Print) WARE, BESSIE -- | | | 2. DATE AND HOUR OF DEATH
OCTOBER 24, 1967 2:25 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
40 ST. AGNES HOSPITAL
CATON & WILKENS AVES.
BALTIMORE, MD. 21229 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND B. COUNTY 21230
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE,
D. STREET ADDRESS (If rural, give location)
2606 PUGET STREET | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
June 6 1898 | 9. AGE in years
lost birth 69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
BUCK BOONE | | | 14. MOTHER'S MAIDEN NAME
MAGDALENE Ogley | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
W | | 16. SOCIAL SECURITY NO.
215-01-4445 | | 17. INFORMANT
ST. AGNES HOSPITAL RECORDS- CATON & WILKENS AVE | |
| 18. 330X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Anterior Myocardial Infarction
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) Cerebral Vascular accident
DUE TO
(B) Arteriosclerosis Heart dis.
DUE TO
(C) Coronary Artery Anomalous. | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCTOBER 12 19 67 to OCTOBER 24 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on OCTOBER 24 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Pauline D. Vasallo | | | | 23B. DATE SIGNED
10-24-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Pauline D. Vasallo | | | | 23D. ADDRESS
St. Agnes Hosp. - CATON & WILKENS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 10-24-67 | | St. Agnes Cat | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. | | | |
| Balto, Md | | OCT 25 1967 | | | |
| 25A. NAME OF REGISTRAR | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| Robert E. Fairbank | | Robert E. Fairbank | | Clay O. Wilson | |

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M-520 67 10171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 10171

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

2. DATE AND HOUR OF DEATH

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

D. STREET ADDRESS

(If rural, give location)

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

3-1-10

9. AGE (In years
lost birthday)

57

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

FRANCIS

14. MOTHER'S MAIDEN NAME

MARIAN PROFORD

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS
21224, MARYLAND

RECORDS: BCH 4940 EASTERN AVE. BALTIMORE

18. 163X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 10/5 19 67 to 10/18 19 67,
that (1) (we) last saw the deceased alive on 10/18 1967 and that in (1) (my) (our) opinion death occurred on the date
and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Neil R. Williamson

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

10/18/67

23C. PHYSICIAN'S
NAME (Type)

DR. NEIL R. WILLIAMSON

M.D.

23D. ADDRESS

BALTIMORE 21224, MARYLAND

BALTIMORE CITY HOSPITALS 4940 EASTERN AVE.

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE RECEIVED BY HEALTH DEPT

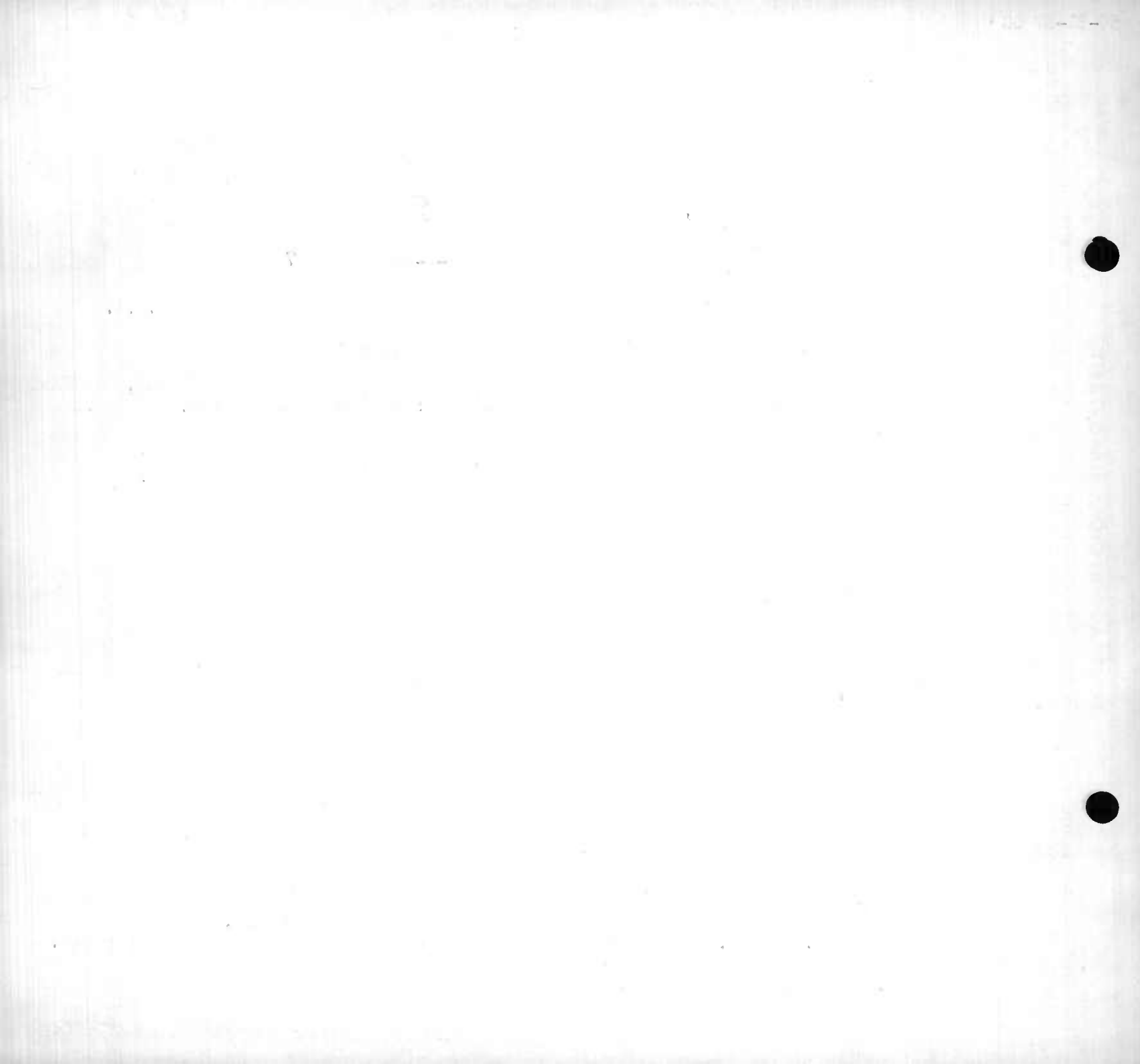
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|-----------|--|------------------|--|--|
| 67 10172 | | 67 10172 | | 67 10172 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED | |
| | | | | George E. Moore | |
| 2. DATE AND HOUR OF DEATH | | Oct. 23, 1967 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | | |
| (If not in hospital or institution, give street address or location) | | B. COUNTY | | | |
| 00 3537 Belair Road | | Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 3537 Belair Rd. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Male | Caucasian | Married | Dec. 5, 1904 | 62 | machinist |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | Tool | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Lawrence Moore | | Elizabeth Adams | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 212-01-0346 | | Mrs. Eleanor C. Moore 3537 Belair Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | acute | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-67 to 10-23-67, that (I) (we) last saw the deceased alive on 10-23-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| C. J. Mendelis | | | | 10/24/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| C. J. Mendelis | | | | 2308 Edmondson Bldg 23rd Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 10/26/67 | | Loudon Park Cemetery | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| OCT 25 1967 | | Robert E. Taylor | | Wm. Cook-Brooks, Inc. 1217 St. Paul St. | |

William C. Brown

10-23-01

Wm. C. Brown

10/23/01
238 E. 4th St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 67 10173 | |
|--|---------------------|--|------------------------------------|---|---|
| BIRTH NO. 67 10173 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Eminian, Hilda S</i> | | 2. DATE AND HOUR OF DEATH
<i>10/23/67 5 50 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Union Memorial Hosp.</i> | | A. STATE <i>Md.</i> B. COUNTY <i>Baltimore Co</i> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<i>204 E. Joppa Rd.</i> | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
<i>7/30/06</i> | 9. AGE (In years last birthday)
<i>61</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Md.</i> | |
| 13. FATHER'S NAME
<i>George Schaffer</i> | | 14. MOTHER'S MAIDEN NAME
<i>Mary Dinmore</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<i>218-07-2324</i> | | 17. INFORMANT <i>Eminian</i> ADDRESS
<i>Mr. E.J. Eminian same as 2-d</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<i>710.0 I</i>
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH
<i>congestive heart failure</i>
<i>Renal Failure</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>4 days</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO <i>Scleroderma</i> | |
| | | (C) <i>W.K.W.</i> | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/18/67</i> to <i>10/23/67</i> , that (I) (we) last saw the deceased alive on <i>10/18/67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>H.F. Holcomb</i> | | | | 23B. DATE SIGNED
<i>10/23/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>HARRY F. HOLCOMB M.D.</i> | | | | 23D. ADDRESS
<i>THE UNION MEMORIAL HOSPITAL</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>Oct. 27, 67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Loudon Park Cemetery</i> | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 25 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Wm. Cook-Brooks Towson</i> | |
| | | | | ADDRESS
<i>1050 York Road Towson, Maryland</i> | |

10/23/63

10/23/63
204 E. 10th St.
Baltimore

Md.
Mary D. Moore

Marion Memorial Hosp.

George Schaeffer
Hawesville

21-22-23

respective trust failure
~~trust failure~~
w/ 2 days
w/ 2 days

10/18/63
10/23/63

Mr. Schaeffer

10/23/63

10/23/63

10/23/63

120 25 74
DEBAUGH, KATHRYN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|------------------|---|-----------------------------------|--|---|---|--|
| BIRTH NO.
120 | | 67 10174 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10174 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print)
Kathryn N. DeBaugh | | | | 2. DATE AND HOUR OF DEATH
10-23-67 11:15 am. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
33 The Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Balt Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Parkton
D. STREET ADDRESS (If rural, give location) Yeong Road | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
10-26-10 | 9. AGE (In years lost birthday)
56 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore Co., Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Benjamin Numbers | | | | 14. MOTHER'S MAIDEN NAME
Hattie Munroe | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
212 03 9639 | | 17. INFORMANT ADDRESS
Hospital Records | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
I
Resp. insuff.
DUE TO
II
Antecedent Causes
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
none - | | | | INTERVAL BETWEEN ONSET AND DEATH
4 mths
4 yrs | | | |
| MEDICAL CERTIFICATION
19A. DATE OF OPERATION
0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
- | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
- | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
- | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
- | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-15 1967 to 10-23 1967, that (I) (we) last saw the deceased alive on 10-23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Antonio Gonzalez-Deila | | | | 23B. DATE SIGNED
10-26-67 | | 23C. PHYSICIAN'S NAME (Type)
Antonio Gonzalez-Deila | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-26-67 | | 24C. NAME OF CEMETERY or CREMATORY
Moreland | | 24D. LOCATION (City, town, or county) (State)
Parkwood, Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
Oct 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks Towson, Towson, Md. | | | |

100-100000



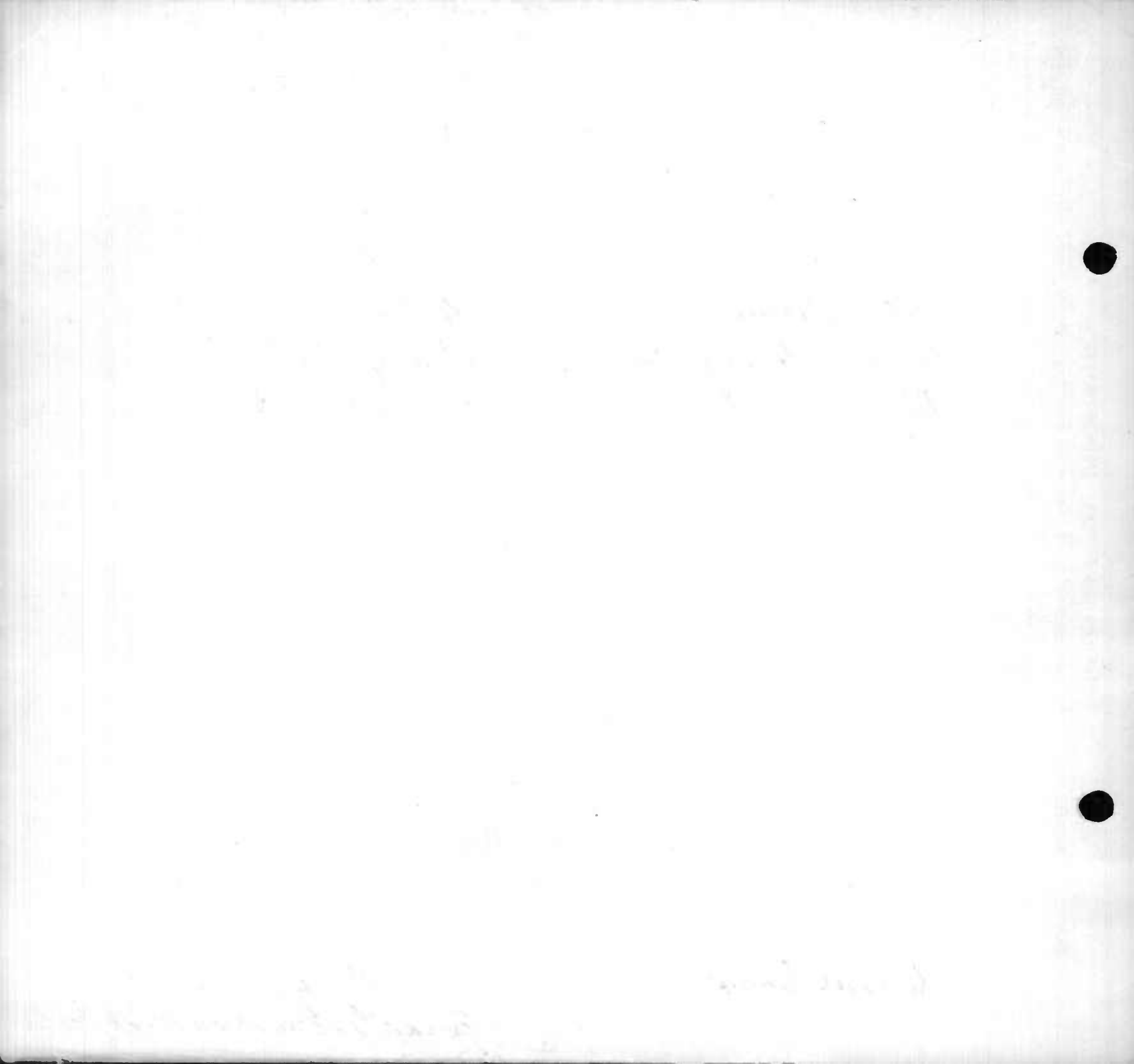
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100-100000

FUNERAL DIRECTOR: IMPORTANT

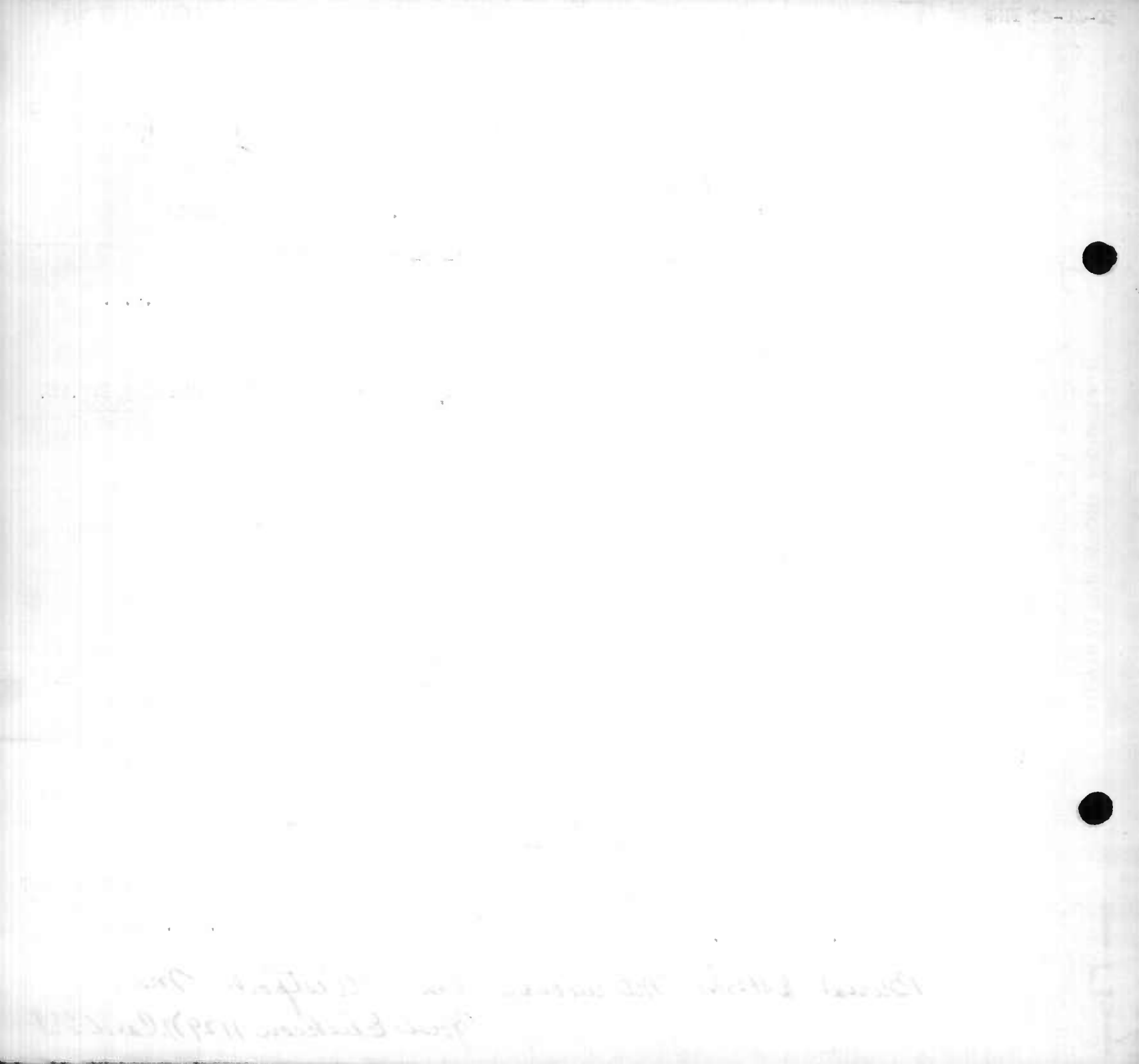
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. T-67 10175 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10175 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED
(Type or Print) BUNN, ELIAS | | |
| 2. DATE AND HOUR OF DEATH
10-18-67 7 P.M. | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE | | | 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
90 Duke Land Nursing Home
1501 N. Duke Land St. | | |
| 6. SEX M | | 7. RACE N | | 8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
MARRIED | |
| 9. DATE OF BIRTH
1-21-94 | | 10. AGE (In years last birthday)
73 | | 11. BIRTHPLACE (State or foreign country)
N. C. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
William Henry Bunn | | 14. MOTHER'S MAIDEN NAME
Mary Westry | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Duke Land Nursing Home | |
| 18. 443 X I | | CAUSE OF DEATH | | ADDRESS
1501 Duke Land St. | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) CEREBRAL HEMORRHAGE
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) HYPERTENSIVE CARDIO-VASCULAR DISEASE
DUE TO | | | |
| (C) | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-6-67 to 10-18-67 , that (I) (we) last saw the deceased alive on 10-18-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Thomas W. Harris | | | | 23B. DATE SIGNED
10-18-67 | |
| 23C. PHYSICIAN'S NAME (Type)
THOMAS W. HARRIS | | | | 23D. ADDRESS
1824 W. Franklin St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal 10/21/67 | | 24B. DATE
10/21/67 | | 24C. NAME of CEMETERY or CREMATORY
Rocky Mount N.C. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR
Zoea E. Erickson 1129 N. Charles | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

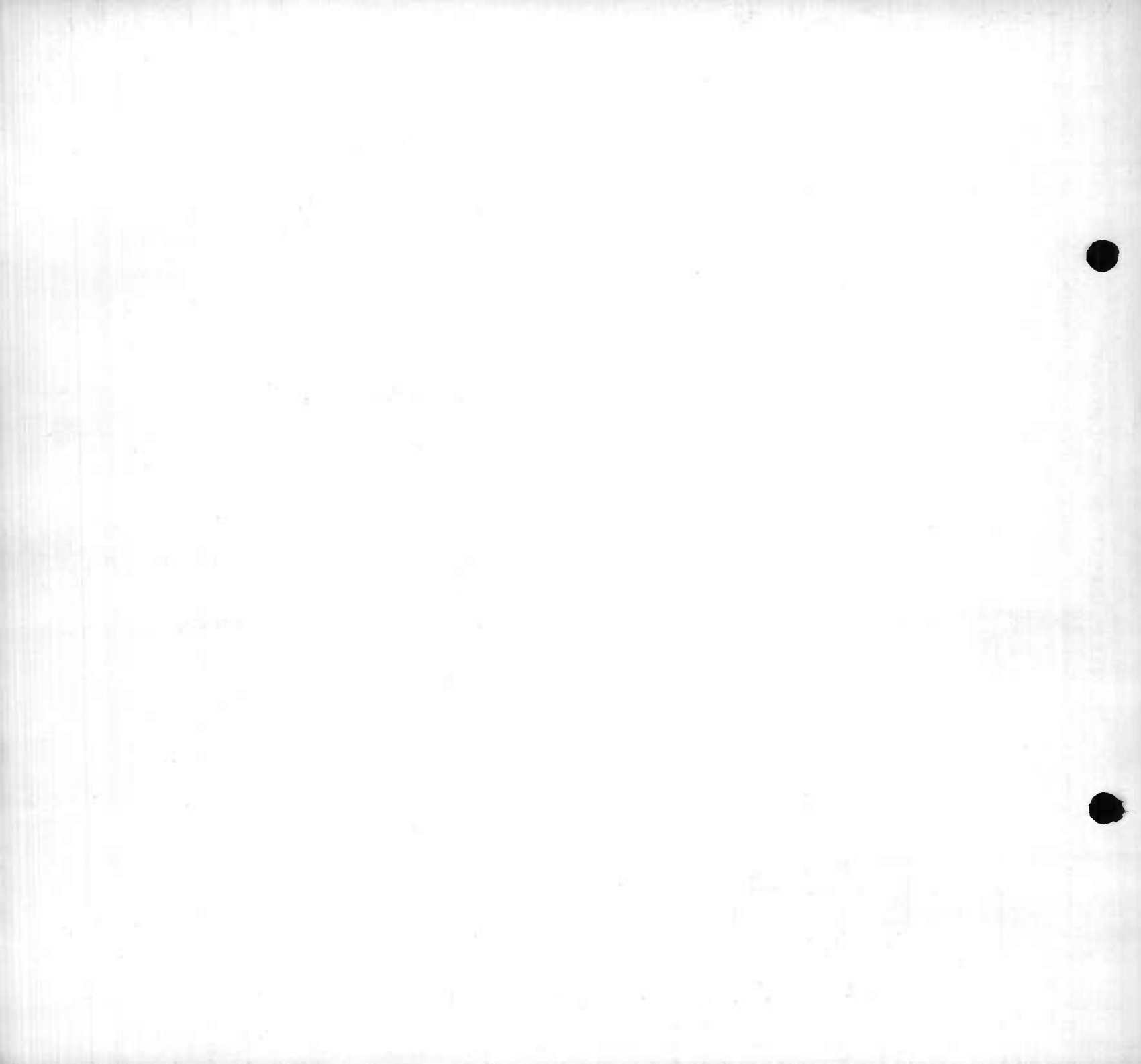
| | | | | | |
|---|-------------------------|---|-------------------------------------|---|--|
| BIRTH NO. T-512 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10176 | |
| M.E. CASE NO. | | 67 10176 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | ALBERTA THOMPSON | | 2. DATE AND HOUR OF DEATH
2:15 AM 20 October 1967 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | A. STATE
MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | C. CITY OR TOWN (If outside city limits, give RURAL and give township)
BALTIMORE | | D. STREET ADDRESS (If rural, give location)
1508 N. BOND STREET 21213 | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
11-27-18 | 9. AGE (In years last birthday)
48 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
DOMESTIC | | 10B. KIND OF BUSINESS OR INDUSTRY
DOMESTIC | | 11. BIRTHPLACE (State or foreign country)
NORTH CAROLINA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
CLARENCE | | 14. MOTHER'S MAIDEN NAME
SPENCER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
BCN: RECORDS 4940 EASTERN AVENUE BALTO. MD. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
154X I
Carcinoma of esophagus
Carcinoma of rectum
Osteomyelitis UTI | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that the (this hospital) attended the deceased from 18 October 1967 to 20 October 1967 , that the last saw the deceased alive on 20 October 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Michael R. McMilliam M.D. | | 23B. DATE SIGNED
20 October 1967 | | 23C. PHYSICIAN'S NAME (Type)
DR. MICHAEL R. MC MILLIAM | |
| 23D. ADDRESS
4940 EASTERN AVENUE BALTO. MD. 21224 | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Oct 25/67 | |
| 24C. NAME OF CEMETERY or CREMATORY
Mt Auburn Cem | | 24D. LOCATION (City, town, or county) (State)
Westport, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | |
| 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
Zorah E. Jackson | | 25D. ADDRESS
1129 N. Carolina St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

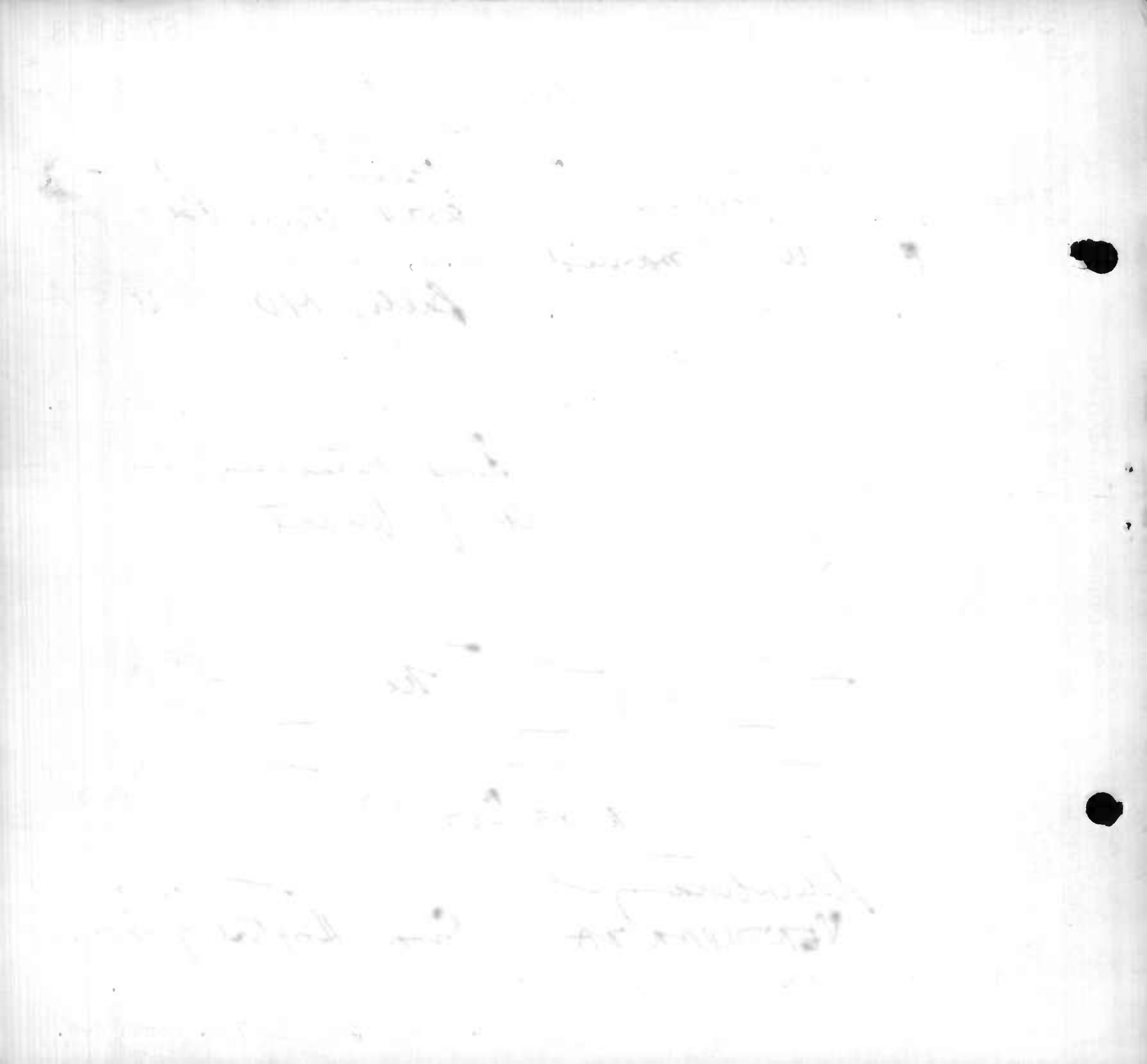
| | | | | | |
|--|---------|--|--|--|---|
| 67 10177 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10177 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | WHITE CLARA | | 10/22/67 8-10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| LUTHERAN HOSPITAL OF MARYLAND | | | MARYLAND | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | BALTIMORE 15-48 | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 2303 GARRISON Blvd | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. Under 1 Yr.
Months Days Hours Min. |
| F | C | | 5-15-33 | 34 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Rhode Island | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Mr Mrlvin White, same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) ACUTE MYOCARDIAL INFARCTION
(B) CORONARY THROMBOSIS
(C) HYPERTENSIVE HEART DISEASE | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | RENAL INSUFFICIENCY | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-17-1967 to 10-22-1967, that (I) (we) last saw the deceased alive on 10-22-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| V. Biswanath Pillai M.D. | | | | 10/22/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| V. BISWANATH PILLAI M.D. | | | | 730 ASHBURTON STREET. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 10/25/67 | | Mt. Calvary Cemetery | |
| | | | | A A County Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| OCT 25 1967 | | Robert E. Fairbank | | A Halstead 1206 W North Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10178 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10178 | |
|--|---------------------|--|--|---|--|--|---|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) <i>Patterson, Gladys M.</i> | | 2. DATE AND HOUR OF DEATH
<i>10-23-67</i> <i>5:30 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>Baltimore</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> <i>27-20</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>42 Sinai Hospital of Baltimore</i> | | | | D. STREET ADDRESS (If rural, give location)
<i>2504 Steele Rd #9</i> | | E. AGE (In years last birthday)
<i>48</i> | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
<i>married</i> | 8. DATE OF BIRTH
<i>Aug. 12, 1919</i> | 9. AGE (In years last birthday)
<i>48</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Ex. Secretary</i> | 11. BIRTHPLACE (State or foreign country)
<i>Balto, MD</i> | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> |
| 13. FATHER'S NAME
<i>William E. Miller</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Goldie C. Dodd</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<i>220-09-2407</i> | | 17. INFORMANT ADDRESS
<i>James E. Patterson 2504 Steele Rd.</i> | |
| 18. <i>170X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Lung metastasis</i>
<i>Cx of breast</i>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<i>10-16-67</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | 21G. DATE OF DEATH
<i>10-23-67</i> | | 21H. DATE OF DEATH
<i>10-23-67</i> | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-16-67</i> to <i>10-23-67</i> and that (I) (we) last saw the deceased alive on <i>10-23-67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Glenn L. Venturan</i> M.D. | | | | 23B. DATE SIGNED
<i>10-23-67</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>Glenn L. Venturan</i> M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>10-26-1967</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Lorraine Park</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Woodlawn Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 25 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Jackson</i> | | 25C. FUNERAL DIRECTOR
<i>G. Howard Strong</i> | | 25D. ADDRESS
<i>3207 W. North Ave.</i> | |



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)J.
MARTIN WARD

2. DATE AND HOUR PRONOUNCED DEAD

October 23, 1967 1:50 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION

6-27-68

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1222 W. Lombard St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widower

8. DATE OF BIRTH

Aug. 3, 1908

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sanitation Dept.

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward B. Ward, Sr.

14. MOTHER'S MAIDEN NAME

Mary F. Kraft

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

214-20-3815

17. INFORMANT ADDRESS

Edward B. Ward, Jr. 600 Woodside Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Intracerebral hemorrhage

(A) DUE TO Cerebrocranial injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Laceration of scalp and focal subarachnoid hemorrhage

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

In front of 1235 W. LOMBARD St.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

10 2 67 6:10p.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject struck during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 23, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10-27-1967

23C. NAME OF CEMETERY or CREMATORY

Lorraine Mausoleum

23D. LOCATION

(City, town, or county)

Woodlawn

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 25 1967

24B. NAME OF REGISTRAR

Robert E. Fisk

24C. FUNERAL DIRECTOR

G. Howard Strong 3207 W. North Ave.,

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10180 | |
|--|---------------------|---|------------------------------------|--|--|
| BIRTH NO. 67 10180 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) JOYNER, JAMES | | 2. DATE AND HOUR OF DEATH
10/23/67 5:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MD. B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION
LUTHERAN HOSPITAL | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| | | | | D. STREET ADDRESS (If rural, give location)
530 N. MOUNT ST. | |
| 5. SEX
M | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
4-16-20 | 9. AGE (In years lost birthday)
47 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
NORTH CAROLINA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
711-03-1293 | | 17. INFORMANT
Gaystella Joyner | |
| | | | | ADDRESS
Same | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
SHOCK
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ACUTE PANCREATITIS-PNEUMO- | | | | INTERVAL BETWEEN ONSET AND DEATH
HOURS
HOURS | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
10 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/23 19 67 to 10/23 19 67 , that (I) (we) last saw the deceased alive on 10/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
F. Queral | | | | 23B. DATE SIGNED
10/23/67 | |
| 23C. PHYSICIAN'S NAME (Type)
F. QUERAL | | 23D. ADDRESS
LUTHERAN HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-23-67 | | 24C. NAME OF CEMETERY or CREMATORY
Balta. Natl. Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Kelson Funeral Home 1348 Calhoun St. | |

10/23/63

10/23/63

10/23/63

LUTHERAN HOSPITAL

BALTIMORE
120 N MOUNT ST.

M
C
Morgue

4-16-20 47

North Carolina

St. A.

20-63-1223 Gaylord/12 Jover

SHOCK

ACUTE PANCREATITIS-PNEUM-
VIA

HOUS

F. QUERAT

Quarant

LUTHERAN HOSPITAL

X

10/23/63

10/23

10/23

10/23

10/23

Barber 10-23-63 Baltimore, Md.
Kipon Turner/ Home 1018 G/ Home

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-----------------------------|--|---|
| K-550 67 10181 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10181 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | |
| | | | | Carrie Kenion | |
| 2. DATE AND HOUR OF DEATH | | 10-23-67 4:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Mercy Hospital | | A. STATE Md
B. COUNTY Balto | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
25-32 | | | |
| | | D. STREET ADDRESS (If rural, give location)
3014 LA RUE SQUARE | | | |
| 5. SEX
F | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
10-8-05 | 9. AGE (In years last birthday)
62 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
So. Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
Fred Hinton | | | |
| 14. MOTHER'S MAIDEN NAME
Lulu Steel | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Martha Thorpe | | ADDRESS
3014 La Rue Square | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH
(A) DUE TO
Pulmonary emboli, bilateral acute
myocardial infarction | | INTERVAL BETWEEN ONSET AND DEATH
acute | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
Arteriosclerotic heart disease
hypertensive heart disease | | (C) DUE TO
Suppurated renal disease
diabetes mellitus | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 19 1967 to Oct. 23 1967, that (I) (we) last saw the deceased alive on Oct. 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Maria Y. Que | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/23/67 | |
| 23C. PHYSICIAN'S NAME (Type)
MARIA Y. QUE | | 23D. ADDRESS
MERCY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/28/67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn | |
| 24D. LOCATION
Baltimore, Md. | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
R. E. F. Adams | | 25C. FUNERAL DIRECTOR
Charles A. Rice | |
| | | | | ADDRESS
661 W. Barnes St | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|----------------------------------|---|---|
| <p>0-550 67 10182</p> <p>CERTIFICATE OF DEATH</p> | | <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>Registered No. 67 10182</p> | |
| <p>BIRTH NO. _____</p> <p>M.E. CASE NO. _____</p> <p>1. NAME OF DECEASED ONNEN, Arnold M, Jr.</p> <p>(Type or Print) ONNEN, ARNOLD</p> | | <p>2. DATE AND HOUR OF DEATH</p> <p>OCT. 23, 1967 10:30 P.M.</p> | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS</p> <p>(If not in hospital or institution, give street address or location) 4940 Eastern Avenue</p> <p>Baltimore, Maryland</p> | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MARYLAND</p> <p>B. COUNTY _____</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE</p> <p>D. STREET ADDRESS (If rural, give location) 4940 Eastern Avenue - 21224</p> | |
| <p>5. SEX Male</p> | <p>6. RACE White</p> | <p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED</p> | <p>8. DATE OF BIRTH 1887</p> <p>7-29-1887</p> |
| <p>9. AGE (In years lost birthday) 80</p> | | <p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p> | <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. desk clerk</p> |
| <p>10B. KIND OF BUSINESS OR INDUSTRY Hotels</p> | | <p>11. BIRTHPLACE (State or foreign country) Maryland</p> | <p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p> |
| <p>13. FATHER'S NAME Arnold M. Onnen</p> | | <p>14. MOTHER'S MAIDEN NAME Mary Marr</p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no</p> | | <p>16. SOCIAL SECURITY NO. unknown</p> | |
| <p>17. INFORMANT RECORDS: Baltimore City Hospitals</p> <p>4940 Eastern Avenue, Baltimore, Md. 21224</p> | | | |
| <p>18. 491X I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | <p>CAUSE OF DEATH</p> <p>(A) Blonchopneumonia</p> <p>DUE TO</p> <p>(B) Chronic obstructive pulmonary disease</p> <p>DUE TO</p> <p>(C) _____</p> | |
| <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>4 days</p> | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> <p>Chronic UTI & azotemia</p> <p>Arteriosclerotic cerebral & coronary vascular disease</p> | | <p>20 years</p> | |
| <p>19A. DATE OF OPERATION 2</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | |
| <p>20A. AUTOPSY? (Yes or No) YES</p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p> | | <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | |
| <p>21F. HOW DID INJURY OCCUR?</p> | | | |
| <p>22. I certify that (I) (this hospital) attended the deceased from 4/13 19 62 to OCT. 23 19 67, that (I) (we) last saw the deceased alive on OCT. 13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | |
| <p>23A. SIGNATURE Benjamin Lechner, MD</p> <p>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p> | | <p>23B. DATE SIGNED OCT. 23, 1967</p> | |
| <p>23C. PHYSICIAN'S NAME (Type) BENJAMIN LECHNER</p> | | <p>23D. ADDRESS 4940 Eastern Avenue, Balto. Md. 21224</p> <p>BALT. CITY HOSP.</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p> | <p>24B. DATE 10/25/67</p> | <p>24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.</p> | <p>24D. LOCATION (City, town, or county) (State) Balto. Md.</p> |
| <p>25A. DATE REC'D BY HEALTH DEPT. OCT 25 1967</p> | | <p>25B. NAME OF REGISTRAR Robert E. Taylor, MD</p> | |
| <p>25C. FUNERAL DIRECTOR Leonard J. Ruck Inc., Balto. Md.</p> | | <p>ADDRESS</p> | |

FUNERAL DIRECTOR: IMPORTANT

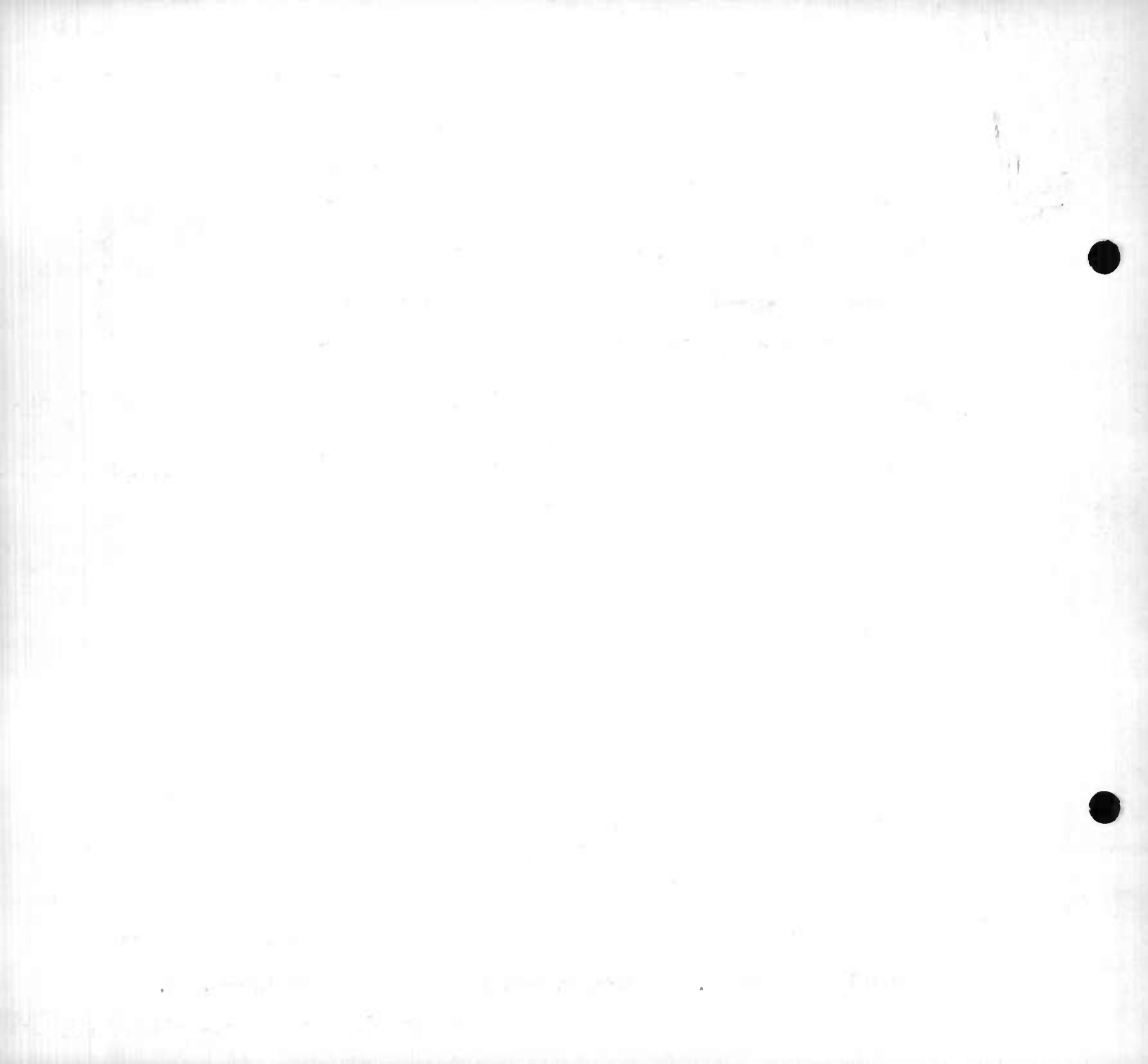
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 10183</u> | |
|--|---------------------|--|------------------------------------|--|---|
| BIRTH NO. <u>67 10183</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>ARTHUR B. OLIVER</u> | | 2. DATE AND HOUR OF DEATH
<u>10/23/67</u> <u>4:15 PM</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>BALTO CITY</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>MD. GENERAL HOSPITAL</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTO</u> <u>26-01</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>4404 ANNUNA AVE, 21206</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>7/16/91</u> | 9. AGE (In years last birthday)
<u>76</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Steel Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>BALTO, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>THOMAS B. OLIVER</u> | | 14. MOTHER'S MAIDEN NAME
<u>EMMA BOEGEL</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-09-2689</u> | | 17. INFORMANT ADDRESS
<u>ALMA OLIVER, WIFE</u> <u>Same</u> | |
| 18. <u>260X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>Pneumonia</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>? Aspiration</u>
<u>Diabetes mellitus</u> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) <u>Uremia</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>prob. 4 days</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/23/67</u> to <u>10/23</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/23</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>A. N. MAVRIDIS</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>10/23/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>A. N. MAVRIDIS</u> | | 23D. ADDRESS
<u>MD. GENERAL HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>10/27/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Baltimore Cemetery</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>Oct 25 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fisher</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10184 | |
|---|-------------------------|---|---|---|--|
| BIRTH NO. 67 10184 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) GEORGE W. ALTHOFF | | 2. DATE AND HOUR OF DEATH
Oct. 25, 1967 12.10 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 5404 Morello Road | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 21214 | | | |
| | | D. STREET ADDRESS (If rural, give location)
5404 Morello Road | | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
6-1-99 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
plasterer (Retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Emmetsburg, Md. | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
George F. Althoff | | | 14. MOTHER'S MAIDEN NAME
Mary Sanders | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mrs. Amy B. Althoff - 5404 Morello Rd. | |
| 18. 260X I CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | (A) Coronary Insufficiency
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
Instant |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Coronary Sclerosis
DUE TO | | 7 years |
| | | | (C) Diabetes Mellitus | | 18 years |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-23-67 19 to 10-25-67 19 that (I) (we) last saw the deceased alive on 10-23-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
C. W. Peake | | | | 23B. DATE SIGNED
10-25-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. C. W. Peake | | | | 23D. ADDRESS
4508 Harford Rd., Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/28/67. | | 24C. NAME of CEMETERY or CREMATORY
Parkwood Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 25 1967 | | 25B. NAME OF REGISTRAR
Robert E. Janney, Jr. | | 25C. FUNERAL DIRECTOR ADDRESS
Leonard J. Ruck, Inc.-Balto., Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|--|------------------------------|--|--|
| J-520 67 10185 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10185 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) JONES, EDNA ELIZABETH | | October 23, 1967 5:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNION MEMORIAL HOSPITAL | | A. STATE MARYLAND B. COUNTY Baltimore | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
REISTERSTOWN (RURAL) | | | |
| | | D. STREET ADDRESS (If rural, give location)
Box 226 RT #2 53-00 | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
06-04-04 | 9. AGE (In years last birthday)
63 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
AMERICAN | | 13. FATHER'S NAME
ROBERT STRICKLIN | | 14. MOTHER'S MAIDEN NAME
MARGARET MON ROE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKNOWN | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MRS VERA CONSTANTINE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from October 16, 1967 to October 23, 1967, that (I) (we) last saw the deceased alive on October 23, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
October 23, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
MIGUEL SANCHEZ PALACIOS, M.D. | | 23D. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10/25/67 | | 24C. NAME OF CEMETERY or CREMATORY
DAVID RIDGE | |
| 24D. LOCATION
BALTO. MD. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 26 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fairbank | | 25C. FUNERAL DIRECTOR
Paul C. Cheneveth 3617 Chestnut Ave. | | | |

JOHN A. HARRIS

JOHN A. HARRIS

JOHN A. HARRIS

MARYLAND

REGISTERED (RURAL)

Box 336 RT #5

02-01-01 03

MARYLAND

MARGARET HEN ROE

JANE

NO RECORD AVAILABLE

ANTHROPOLOGICAL OBSERVATIONS

UNION MEMORIAL HOSPITAL

W. W. W. W.

HOSPITAL

ROBERT STRICKLAND

UNKNOWN

NO

October 23 03
October 19 03
October 23 03

Handwritten signature

MICHAEL SANCHEZ BRUNO

UNION MEMORIAL HOSPITAL

October 23 03

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|-------------------------|--|--|
| <div style="display: flex; justify-content: space-between;"> 2-520 67 10186 BALTIMORE CITY HEALTH DEPARTMENT </div> | | <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH Registered No. 67 10186 </div> | |
| BIRTH NO.
M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) MARYANNA ZIEMSKI <i>Maryanna Ziemiński</i> | | 2. DATE AND HOUR OF DEATH
10/20/67 <i>6:30 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
90 Bolton Hill Nurs. & Conv. Center | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) TOWSON <i>53-00</i>
D. STREET ADDRESS (If rural, give location) 602 Goucher Blvd. | |
| 5. SEX
Female | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
10-18-83 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years lost birthday)
84 |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
William Kordonowski | | 14. MOTHER'S MAIDEN NAME
Catherine Pakulski | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-10-0967D | |
| 17. INFORMANT
Bolton Hill Nurs. & Conv. Center
1400 Johns Street (Balt.) | | 18. ADDRESS | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebral thrombosis
INTERVAL BETWEEN ONSET AND DEATH | | (A) DUE TO | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/20/67 19 to 10/20/67 19 that (I) (we) lost saw the deceased alive on 10/20/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>[Signature]</i> | | 23B. DATE SIGNED
10/20/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Hon. E. J. [Signature] | | 23D. ADDRESS
930 WHITE ROCK ST. BALT. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/24/67 | |
| 24C. NAME OF CEMETERY or CREMATORY
St. Stanislaus Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 26 1967 | | 25B. NAME OF REGISTRAR
Robert E. [Signature] | |
| 25C. FUNERAL DIRECTOR
John J. Duda, 2829 Hudson St. Balto. Md. | | 25D. ADDRESS | |

10/2/22

10/2/22

10/2/22

10/2/22

10/2/22

10/2/22

10/2/22

10/2/22

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10187 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10187 | |
|--|-------------------------|--|---------------------------------------|---|---|---|--|
| 1. NAME OF DECEASED
(Type or Print) YANKY, RUDOLPH | | | | 2. DATE AND HOUR OF DEATH
October 24th, 1967 8:20 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland B. COUNTY Anne Arundel | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
40 Saint Agnes Hospital
Caton & Wilkens Ave.
21229 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Glen Burnie 52-00 | | | |
| | | | | O. STREET ADDRESS (If rural, give location)
204 Wellham Ave. N/W | | | |
| 5. SEX
M | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
11/11/1899 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Crane Operator Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
Bethlehem- Steel | | 11. BIRTHPLACE (State or foreign country)
Anne Arundel Co., Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Agustva Yanky | | | | 14. MOTHER'S MAIDEN NAME
Christina (unknown) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-18-2623 | | 17. INFORMANT ADDRESS
Mrs. Anna Yanky (wife) Same as #4 | | | |
| 18. 4201 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
myocardial infarction
ASCVD | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/20 19 65 to 10/24 19 67 , that (I) (we) last saw the deceased alive on 9/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Eugenio E. Benitez M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 10/24/67 | |
| 23C. PHYSICIAN'S NAME (Type) Eugenio E. Benitez M.O. | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/27/67 | | 24C. NAME OF CEMETERY or CREMATORY
Meadowridge Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Howard Co. RFD Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 26 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS
Singleton Funeral Home
Glen Burnie, Md | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. | |
|--|--|----------|--|----------------|--|
| 67 10188 | | 67 10188 | | 67 10188 | |
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. M.E. CASE NO. </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> 1. NAME OF DECEASED
(Type or Print) 2. DATE AND HOUR OF DEATH </div> | | | <div style="display: flex; justify-content: space-between;"> 3. PLACE OF DEATH IN BALTIMORE, MARYLAND 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) </div> | | |
| <div style="display: flex; justify-content: space-between;"> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) </div> | | | <div style="display: flex; justify-content: space-between;"> 5. CITY OR TOWN (If outside city limits, write RURAL and give township) 6. COUNTY </div> | | |
| <div style="display: flex; justify-content: space-between;"> 7. SEX 8. RACE </div> | | | <div style="display: flex; justify-content: space-between;"> 9. MARRED, NEVER MARRED, WIDOWED, DIVORCED (specify) 10. DATE OF BIRTH </div> | | |
| <div style="display: flex; justify-content: space-between;"> 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. KIND OF BUSINESS OR INDUSTRY </div> | | | <div style="display: flex; justify-content: space-between;"> 13. BIRTHPLACE (State or foreign country) 14. CITIZEN OF WHAT COUNTRY? </div> | | |
| <div style="display: flex; justify-content: space-between;"> 15. FATHER'S NAME 16. MOTHER'S MAIDEN NAME </div> | | | <div style="display: flex; justify-content: space-between;"> 17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 18. SOCIAL SECURITY NO. </div> | | |
| <div style="display: flex; justify-content: space-between;"> 19. INFORMANT 20. ADDRESS </div> | | | <div style="display: flex; justify-content: space-between;"> 21. INTERVAL BETWEEN ONSET AND DEATH </div> | | |
| <div style="display: flex; justify-content: space-between;"> 22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 23. CAUSE OF DEATH </div> | | | <div style="display: flex; justify-content: space-between;"> 24. DUE TO </div> | | |
| <div style="display: flex; justify-content: space-between;"> 25. ANTECEDENT CAUSES 26. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. </div> | | | <div style="display: flex; justify-content: space-between;"> 27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. </div> | | |
| <div style="display: flex; justify-content: space-between;"> 28. DATE OF OPERATION 29. CONDITION FOR WHICH OPERATION WAS PERFORMED </div> | | | <div style="display: flex; justify-content: space-between;"> 30. AUTOPSY? (Yes or No) 31. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? </div> | | |
| <div style="display: flex; justify-content: space-between;"> 32. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) </div> | | | <div style="display: flex; justify-content: space-between;"> 34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) </div> | | |
| <div style="display: flex; justify-content: space-between;"> 35. TIME OF INJURY (Month) (Day) (Year) (Hour) 36. INJURY OCCURRED </div> | | | <div style="display: flex; justify-content: space-between;"> 37. HOW DID INJURY OCCUR? </div> | | |
| <div style="display: flex; justify-content: space-between;"> 38. I certify that (this hospital) attended the deceased from 39. (we) lost saw the deceased alive on </div> | | | <div style="display: flex; justify-content: space-between;"> 40. and that in (our) opinion death occurred on the date </div> | | |
| <div style="display: flex; justify-content: space-between;"> 41. and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. </div> | | | <div style="display: flex; justify-content: space-between;"> 42. SIGNATURE 43. DATE SIGNED </div> | | |
| <div style="display: flex; justify-content: space-between;"> 44. PHYSICIAN'S NAME (Type) 45. ADDRESS </div> | | | <div style="display: flex; justify-content: space-between;"> 46. DATE 47. NAME OF CEMETERY or CREMATORY </div> | | |
| <div style="display: flex; justify-content: space-between;"> 48. BURIAL CREMATION, REMOVAL (Specify) 49. LOCATION (City, town, or county) </div> | | | <div style="display: flex; justify-content: space-between;"> 50. DATE RECD BY HEALTH DEPT. 51. NAME OF REGISTRAR </div> | | |
| <div style="display: flex; justify-content: space-between;"> 52. FUNERAL DIRECTOR 53. ADDRESS </div> | | | <div style="display: flex; justify-content: space-between;"> 54. DATE 55. NAME OF REGISTRAR </div> | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|---|--|
| BIRTH NO. 67 10189 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10189 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Christie M. Griffith | | October 23, 1967 | | 7:55 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| Gould Convalesarium
6116 Belair Road. | | Maryland | | | |
| 90 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | 25-04 | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 3830 8th Street 21225 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Female | White | Widowed | July 21, 1892 | 75 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired Clerk | | Dept. Store | | Crisfield, Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Warren Mason | | Carrie Swift | | U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | 21229 | |
| | | Mr. H. Frank Griffith | | 717 Dorchester Road | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | Arteriosclerotic C-V disease 20 yrs
Associated Chronic myocarditis | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Malnutrition & Senility | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 11, 1967 to October 23, 1967, that (I) was last saw the deceased alive on Oct. 22, 1967 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) was (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> | Med. Director <input type="checkbox"/> | Staff Phys. <input type="checkbox"/> | |
| H. V. Harbold | | | | Oct. 24, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| H. V. HARBOLD | | 4706 Harford Road Baltimore 14, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 10/26/67 | Glen Haven Memorial Park | | Glen Burnie, Md. | |
| 25A. DATE RECEIVED BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| Oct 26 1967 | | Robert E. Isakson, M.D. | | McGully Funeral Home 237 Patapsco Ave. 21225 | |

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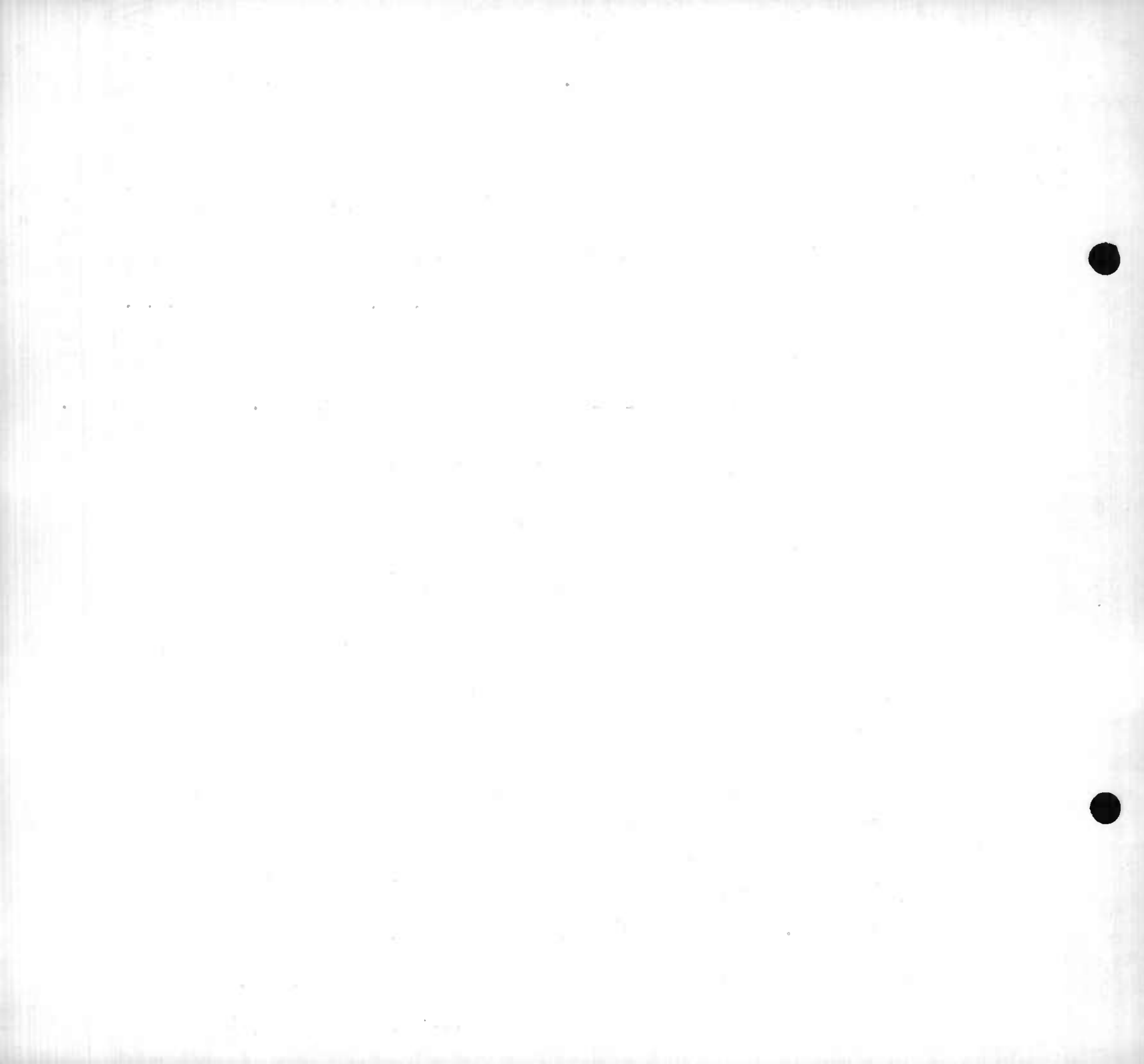
100-100000-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|------------------|---|----------------------------------|--|--|--|--|
| BIRTH NO.
H-416 | | 67 10190 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10190 | |
| 1. NAME OF DECEASED
(Type or Print)
HILLEBRAND, Frances M. | | | | 2. DATE AND HOUR OF DEATH
October 23, 1967 6 a M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
00 508 South Quail Street
Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
508 South Quail Street #24 26-05 | | | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed | 8. DATE OF BIRTH
May 18, 1881 | 9. AGE (In years lost birthday)
86 yrs | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Char Lady | | 10B. KIND OF BUSINESS OR INDUSTRY
1st National Bank | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Eydelloth | | | | 14. MOTHER'S MAIDEN NAME
Barbara Loeffler | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
217-14-1267 | | 17. INFORMANT ADDRESS
Madeline Ortt, dght., 3444 Erdman Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) DUE TO Coronary Thrombosis Immediate
(B) DUE TO arteriosclerotic C.V.D.
(C) | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-18-1964 to 10-23-1967, that (I) (we) lost saw the deceased alive on 10-11-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
John Costantini | | | | 23B. DATE SIGNED
10-24-67 | | 23C. PHYSICIAN'S NAME (Type)
Dr. John Costantini | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/26/67 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 26 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Schimunek Funeral Home
3331 Brehms Lane #13 | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|------------------|---|--|---|--|--|-------------------------------|
| BIRTH NO. K-500 | | 67 10191 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10191 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Russell A. Keeney | | | | 2. DATE AND HOUR OF DEATH
Oct 23 1967 8:15A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Sinai Hosp. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-17
D. STREET ADDRESS (If rural, give location) 5332 Hamlin Ave. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
10-8-00 | 9. AGE (In years last birthday)
67 | 10. Under 1 Yr. Months: Days | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | 10B. KIND OF BUSINESS OR INDUSTRY
Baltimore Transit Co | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Charles Keeney | | | | 14. MOTHER'S MAIDEN NAME
Annie Beard | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes W #1 | | 16. SOCIAL SECURITY NO.
214-03-7763A | | 17. INFORMANT ADDRESS
Mrs. Sophia Keeney, 5332 Hamlin Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ASCVD
diabetes mellitus
Cardiac arrest | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH
>20 years
>20 yrs
7:17-8:15AM | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Old MI-1967 | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7:17 AM to 8:15 AM 19 67 to 8:15 AM 19 67 that (I) (we) last saw the deceased alive on 8:15 AM 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
AS Rushak M.D. | | | | 23B. DATE SIGNED
Oct 23 | | | |
| 23C. PHYSICIAN'S NAME (Type)
AS Rushak M.D. | | | | 23D. ADDRESS
Sinai Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/26/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE RECORDED BY HEALTH DEPT.
Oct 26 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farber | | 25C. FUNERAL DIRECTOR
Lo. Vernon Lemmon | | ADDRESS
4611 Park Heights Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10192 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10192 | |
|--|-------------------------|--|-----------------------------------|---|-------------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print) <i>Mary E. Miller</i> | | | | 2. DATE AND HOUR OF DEATH
<i>10-25-67 6:05 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>43 South Baltimore General Hosp.</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>23-61</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21230</i>
D. STREET ADDRESS (If rural, give location) <i>132 W. CLEMENT ST.</i> | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widow</i> | 8. DATE OF BIRTH
<i>4-1-95</i> | 9. AGE (In years last birthday)
<i>72</i> | If Under 1 Yr.
Months Days | If Under 24 Hrs.
Hours Min. | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>At Home</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Harry Smith</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Elizabeth</i> | | | |
| 15. Was Deceased Ever in U.S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Mr. Charles S. Miller</i> | | ADDRESS
<i>1320 Maple Ave. 27</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <i>Uremia</i>
DUE TO
(B) <i>Chronic renal failure</i>
DUE TO
(C) <i>Diabetes mellitus</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>3 years</i>
<i>3 years +</i>
<i>Undetermined</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from <i>10-15</i> 19 <i>67</i> to <i>10-25</i> 19 <i>67</i> , that (we) lost saw the deceased alive on <i>10-25</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>John Albert Bigbee</i> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>10-25-67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>John Albert Bigbee</i> M.D. | | | | 23D. ADDRESS
<i>1213 Light St.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>10 28 67</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Greenmount</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Balto. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 26 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR
<i>Mc Cully</i> | | ADDRESS
<i>130 E. Fort Ave</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT
Registered No. 67 10193 | |
| 67 10193 CERTIFICATE OF DEATH | |
| BIRTH NO. 67 10193
M.E. CASE NO. 67 10193
1. NAME OF DECEASED (Type or Print) LATTA, WALTER TWILLEY | |
| 2. DATE AND HOUR OF DEATH
OCTOBER 23, 1967 10:35A. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
40 ST. AGNES HOSPITAL | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 2505 MARBOURNE AVE. 21230 | |
| 5. SEX MALE
6. RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 3/7/01
9. AGE (In years lost birthday) 66
If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER FOREMAN
10B. KIND OF BUSINESS OR INDUSTRY CHES-MAR, CORP
11. BIRTHPLACE (State or foreign country) TENNESSEE
12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CARTER LATTA
14. MOTHER'S MAIDEN NAME NELLIE LATTA Twilley | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE
16. SOCIAL SECURITY NO. 217-07-7739
17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)
Massive pulmonary embolism
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Ca of Tete of pancreas | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 19A. DATE OF OPERATION 10/23/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from OCTOBER 9 19 67 to OCTOBER 23 19 67 , that (I) (we) last saw the deceased alive on OCTOBER 23 19 67 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE Walter Twilley
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) Walter Twilley
23D. ADDRESS BALTO, MD. 21229 ST. AGNES HOSP; CATON & WILKENS AVES. | |
| 24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) Burial Oct. 25, 1967
24C. NAME of CEMETERY or CREMATORY Meadowridge Cem.
24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 26 1967
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.
25C. FUNERAL DIRECTOR ADDRESS G. Truman Schwab 3512 Frederick Ave. Balto. Md. | |

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BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LORRAINE PATTERSON

2. DATE AND HOUR PRONOUNCED DEAD

October 2, 1967

1:25 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1355 Gorsuch Ave.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

5-11-28

9. AGE (In years last birthday)

39

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Wilson, N.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George Covington

14. MOTHER'S MAIDEN NAME

Agnes Covington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or drunk town) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Elliot Patterson - 1355 Gorsuch Ave.

ADDRESS

18.

E888.19

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)(A) ~~DUE TO~~

Ingestion of alcohol & Amitriptyline

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Unknown

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Unknown 00-00

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

Unknown m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Unknown institutional

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE

Edward F. Wilson

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

October 3, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

10-6-67

23C. NAME of CEMETERY or CREMATORY

Baltimore Hospital

23D. LOCATION

Baltimore

(City, town, or county)

(State)

md

24A. DATE REC'D BY HEALTH DEPT.

OCT 26 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Turnell S. Olsen - Balto. Md.

ADDRESS

(505-22)

3-11-22
William H. C. Smith
Upper T. 100 ft
Blount Station-100 ft

Henry
George Thompson
No

Indication

X

Base of 100 ft. section
Thickened 100 ft.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|-----------|--|----------------------------|--|--|
| 67 10195 | | 67 10195 | | 67 10195 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | (Type or Print) FIGGS, SARAH | | 10/15/67 2.10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF LUTHERAN HOSPITAL (If not in hospital or institution, give street address or location) | | A. STATE Md | | B. COUNTY | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location) | | 1545 BRUCE ST. | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 8-21-1896 | 9. AGE (In years lost birthday) 71 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME Eli Hawkins | | 14. MOTHER'S MAIDEN NAME Jane Wilson | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-308089A | | 17. INFORMANT Address | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) CEREBRAL VASCULAR ACCIDENT | | HOURS | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) CEREBRAL ARTERIOSCLEROSIS | | YEARS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/13 19 67 to 10/15 19 67, that (I) (we) last saw the deceased alive on 10/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE F. Queral | | 23B. DATE SIGNED 10/15/67 | |
| 23C. PHYSICIAN'S NAME (Type) F. QUERAL | | 23D. ADDRESS M.D. LUTHERAN HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10/19/67 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral | |
| 24D. LOCATION (City, town, or county) Balto. | | 24E. STATE Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. 10/26/1967 | | 25B. NAME OF REGISTRAR Robert E. Fickens | | 25C. FUNERAL DIRECTOR Address | |
| | | Turnell S. Qden. Balto Md. | | | |

SALE PRICE
1747 BUCKS

15

10

10

CEDERHOLM VASSAL AND SONS

CEDERHOLM ANTIKVARIEBOK

NO

12

10/12

10/12

X

Good

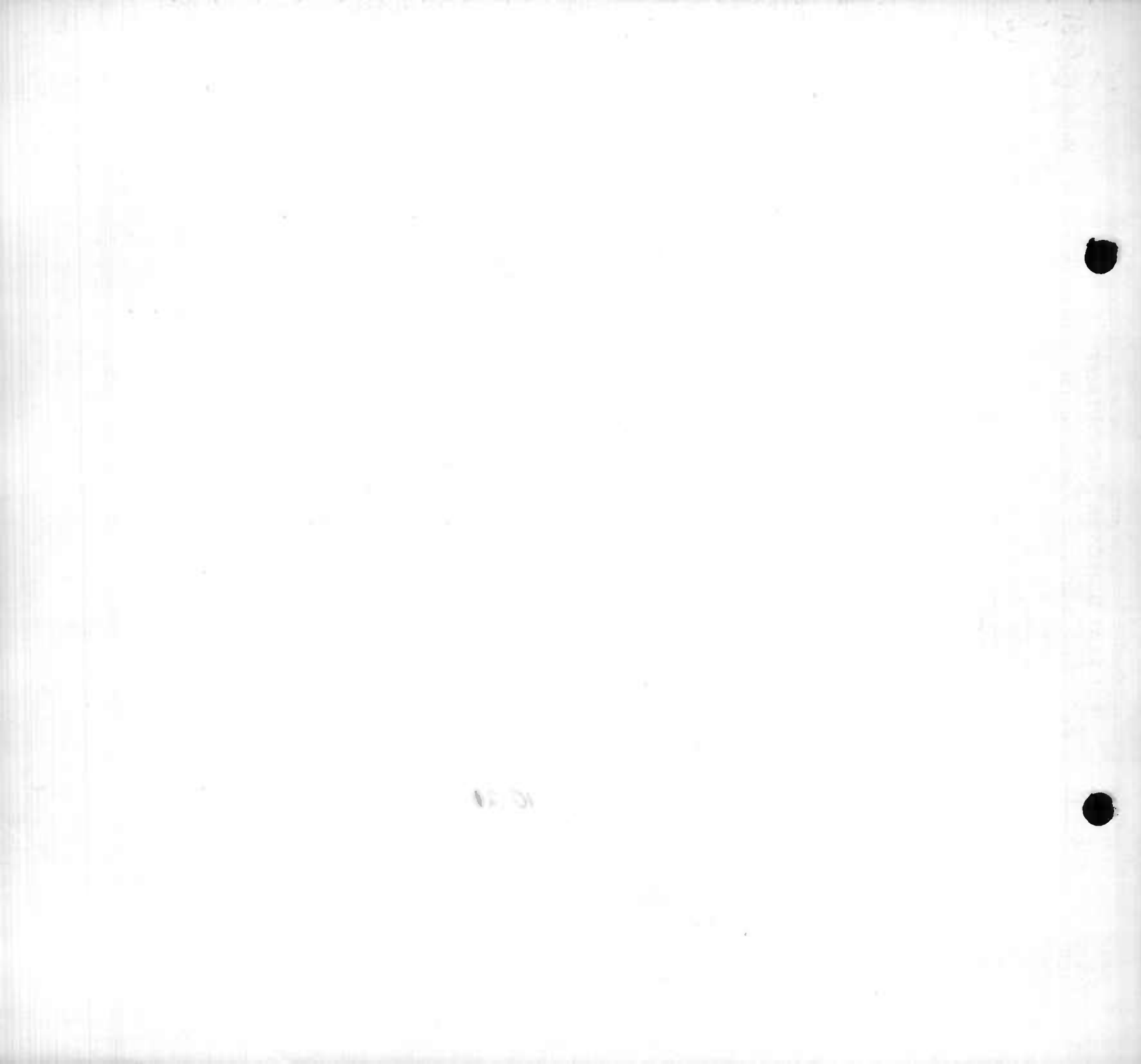
LUTHERAN HOSPITAL

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

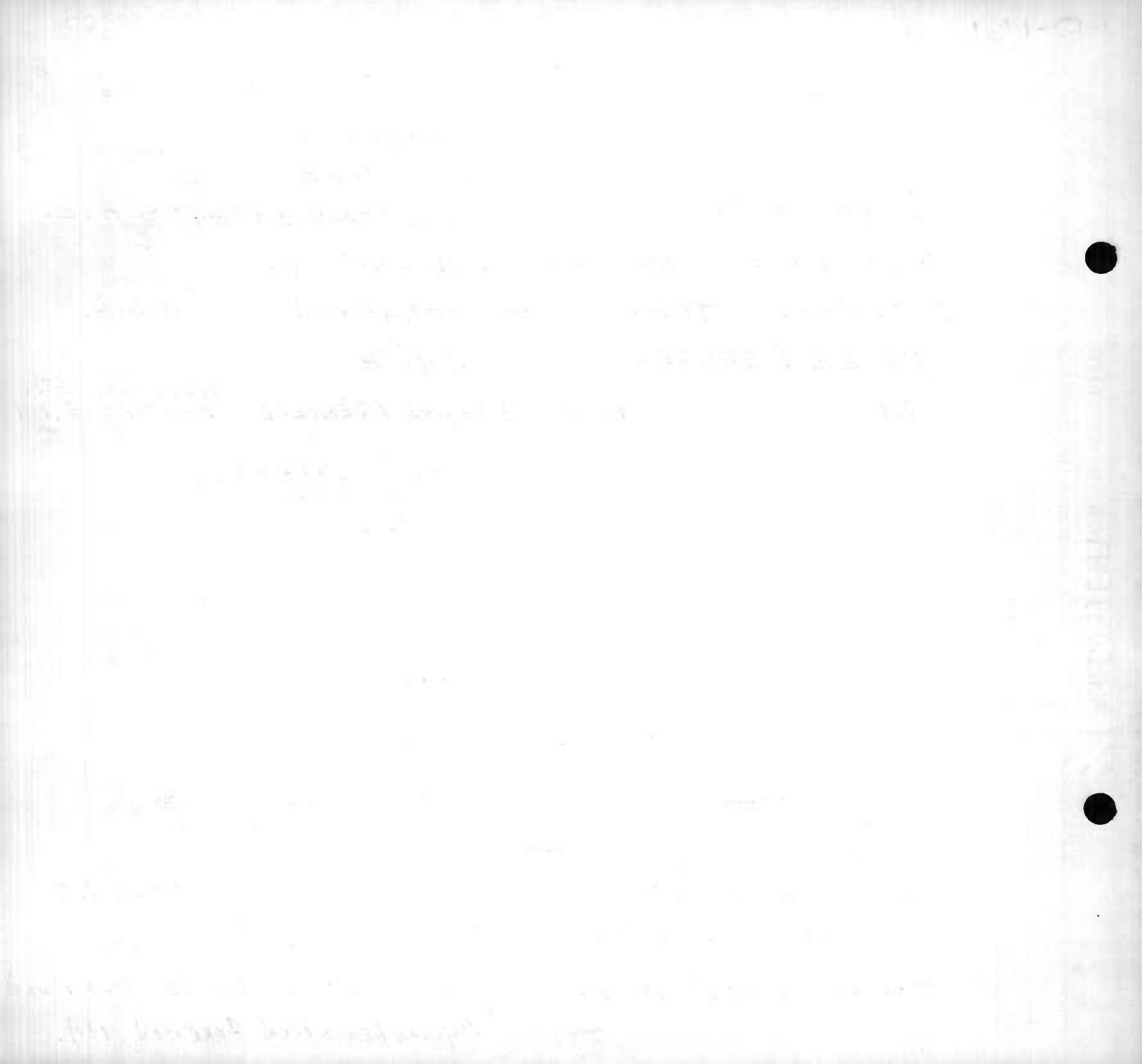
| | | | | | |
|--|-------------------------|---|-------------------------------------|---|--|
| BIRTH NO. 67 10196 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10196 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) CODE, JAMES E. | | 2. DATE AND HOUR OF DEATH
October 22, 1967 12:25A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore City | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Johns Hopkins Hospital | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location)
969 N. Wolfe St. | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
11/14/12 | 9. AGE (In years last birthday)
54 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
FRANK CODE | | 14. MOTHER'S MAIDEN NAME
BERTHA STEWART | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Bertha Code 969 N. Wolfe St. | |
| 18. 178X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Gram negative sepsis | | CAUSE OF DEATH
(A) DUE TO
Gram negative sepsis | | INTERVAL BETWEEN ONSET AND DEATH
12 hours | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
Carcinoma of pharynx | | One year | |
| (C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
7/25/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ca. pharynx | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/20/67 19 to 10/22 19 67 , that (I) (we) last saw the deceased alive on 10/22/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
David J. Shaw | | | | 23B. DATE SIGNED
10/22/67 | |
| 23C. PHYSICIAN'S NAME (Type)
David J. Shaw | | | | 23D. ADDRESS
Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/27/67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Anne Arundel Cty. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 26 1967 | | 25B. NAME OF REGISTRAR
P. B. E. F. Shaw | | 25C. FUNERAL DIRECTOR
Wm March 928 E. North Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

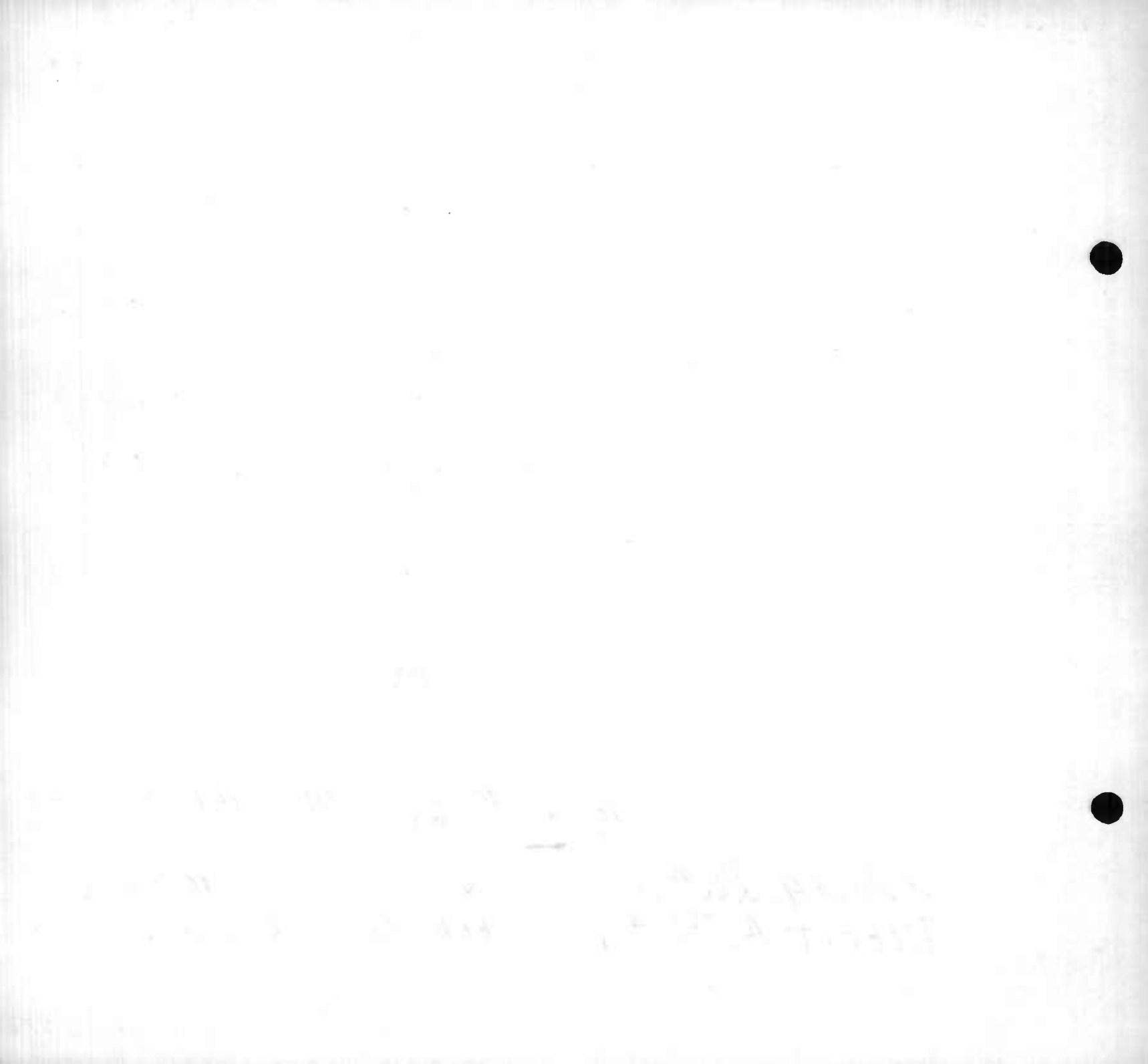
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| 67 10197 | | | | | Registered No. 67 10197 | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| LOUIS WILLIAM OBERFELD | | | | | 10/24/67 1 1430 M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSPITAL | | | | | MARYLAND | | | | |
| 5. SEX 6. RACE 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)
MALE WHITE MARRIED | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 27-20 | | | | |
| 8. DATE OF BIRTH 9. AGE (In years lost birthday)
6-16-1905 62 | | | | | D. STREET ADDRESS (If rural, give location)
7121 PARK HEIGHTS AVE. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
DIST. MGR. | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
TRUCK RENTAL | | | | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | |
| 13. FATHER'S NAME
MEYER OBERFELD | | | | | 14. MOTHER'S MAIDEN NAME
EDITH | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | | 16. SOCIAL SECURITY NO.
217-18-1939 | | | | |
| 17. INFORMANT
MAYME OBERFELD | | | | | ADDRESS
7121 PARK HGTS. BALTIMORE, MD | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | INTERVAL BETWEEN ONSET AND DEATH
Cerebrovascular Accident - Diseases of the A.S. | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20A. AUTOPSY? (Yes or No)
NO | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 19 66 to 19 67 that (I) (We) last saw the deceased alive on 10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Leonard H. Hister M.D. | | | | | 23B. DATE SIGNED
10/24/67 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Leonard H. Hister M.D. | | | | | 23D. ADDRESS
7111 Park Heights Ave | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | | | 24B. DATE
10-29-67 | | | | |
| 24C. NAME of CEMETERY or CREMATORY
UNITED HEBREW | | | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE Co. MARYLAND | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 26 1967 | | | | | 25B. NAME OF REGISTRAR
Robert E. Finkbeiner | | | | |
| 25C. FUNERAL DIRECTOR
SYLVAN LEWIS & SON GARRISON, MD. | | | | | ADDRESS | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

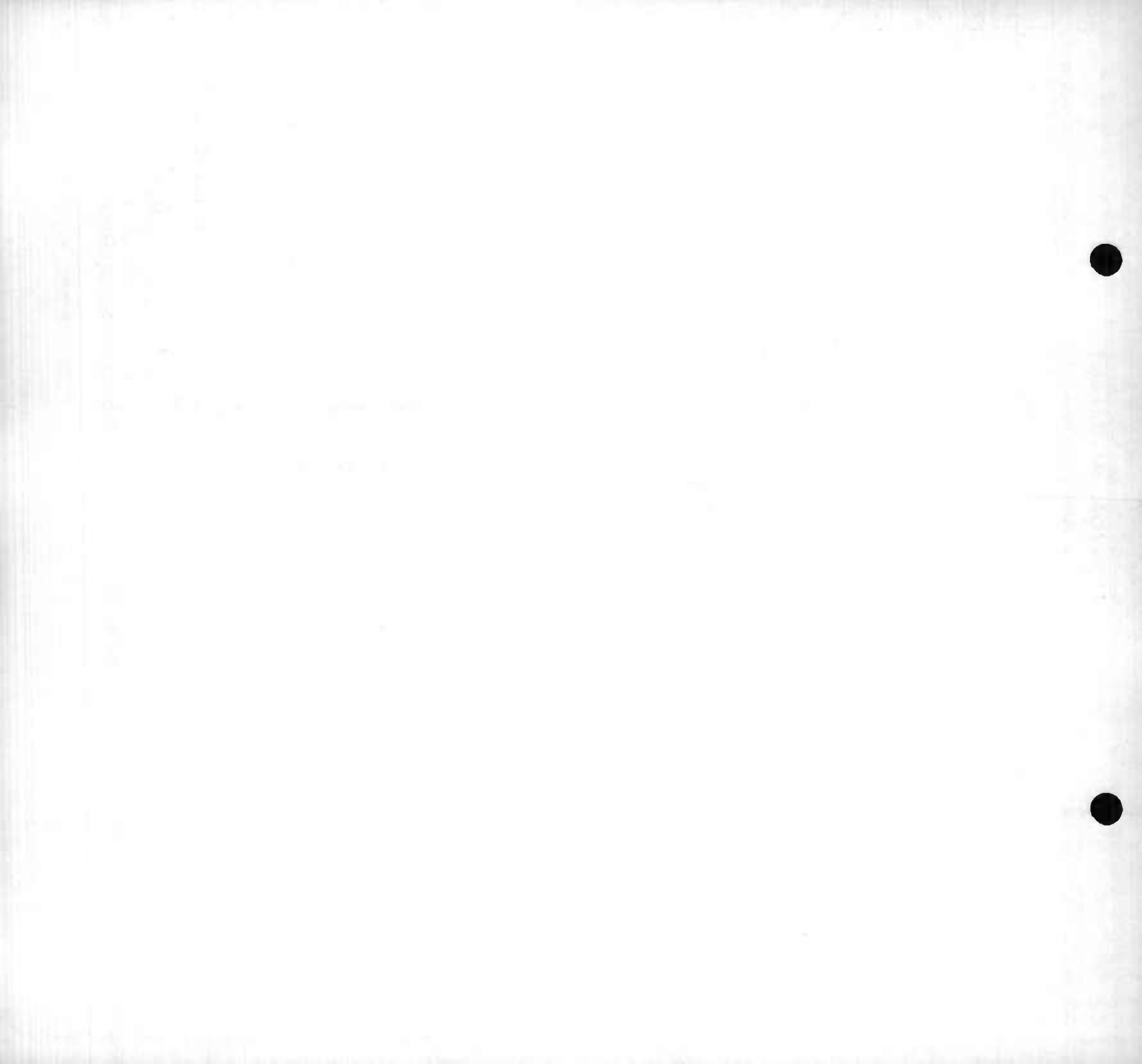
| | | | | | |
|---|---------|--|---|--|---|
| BIRTH NO. 67 10198 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10198 | |
| M-262 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| MAX MOKROUS | | | OCT 24 1967 620P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| KENESAW NURSING HOME
2601 ROSLYN AVE | | | MARYLAND | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | D. STREET ADDRESS (If rural, give location) | | |
| BALTIMORE | | | 527 N CAROLINE ST | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| MALE | WHITE | NEVER MARRIED | UNK | 80 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RETIRED STEVEDORE | | UNK | | POLAND | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| DANIEL MOKROUS | | | BARBARA UNK. | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 21507-4017 | | PAULINE KOVALCHUK 9 S JENNEY ST | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| (A) Coronary occlusion | | | 20 min. | | |
| ANTECEDENT CAUSES | | | (B) DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/22 1967 to 10/24 1967 that (I) (we) last saw the deceased alive on 10/24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Robert A. Reiter | | | | 10/26/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Robert A. Reiter | | | | 606 Edmondson Ave 21228 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | OCT 26 1967 | | HOLY TRINITY CHM. | |
| | | | | ELK RIDGE 140 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| OCT 26 1967 | | Robert E. Taylor, M.D. | | DIPPEL BROS INC 1800E LOMBARD ST | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10199 | |
|--|-----------|--|---|---|---|
| 67 10199 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO.
M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | CHARLES J. LOSENICKY | | OCT 23 1967 11:30 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE
B. COUNTY | |
| CHURCH HOME + HOSPITAL | | | | MARYLAND | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | | | BALTIMORE | |
| | | | | D. STREET ADDRESS (If rural, give location) | |
| | | | | 1822 E LOMBARD STREET | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
lost birthday) | 10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) |
| MALE | WHITE | MARRIED | DEC 7 1918 | 48 | BEER BONER |
| 10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF
WHAT COUNTRY? |
| S&K-ESSKAY | | | BALTIMORE MD | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| JOSEPH LOSENICKY | | | LILLIAN MOREWITZ | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES WORLD WAR II | | 216-074707 | | CATHERINE LOSENICKY 1822 E LOMBARD ST | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) <i>Cerebral Hemorrhage</i> | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | DUE TO <i>arterial Hypertension</i> | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) <i>Diabetes mellitus</i> | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July</i> 1962 to <i>Oct 23</i> 1967, that (I) (we) last saw the deceased alive on <i>Oct 23</i> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Approved by Med Ex. Office George D Lippy</i> | | | | 23B. DATE SIGNED | |
| M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| George D. Lippy | | M.D. 426 S. Patterson St Baltimore Ind 21231 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | OCT 26 67 | BALTO NATIONAL CFM | | FREDERICK ROAD MD | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| OCT 26 1967 | | Robert E. Farber | | DIPPEL BROS INC 1800 E LOMBARD ST | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|------------------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. <u>67 10200</u> | |
| BIRTH NO. <u>H-252 67 10200</u> | | | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) <u>Walter H. Hawkins</u> | | 2. DATE AND HOUR OF DEATH
<u>Oct 24, 1967</u> <u>3 A.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>House In The Pines Nursing Home</u>
<u>5837 Belair Road</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>Balt</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>116 Raspe Ave</u> | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>July 15, 1896</u> |
| 9. AGE (In years last birthday)
<u>71</u> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Norris Co.</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Cornwall Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Charles H. Hawkins</u> | | 14. MOTHER'S MAIDEN NAME
<u>Martha E. Carroll</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>215-09-7948</u> | |
| 17. INFORMANT
<u>Mrs. Ruth A. Hawkins</u> | | ADDRESS
<u>116 Raspe Ave</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
<u>Cause of bleed</u> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
<u>1810</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
<input type="checkbox"/> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JUNE 2, 1964</u> to <u>OCT 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>OCT 3, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<u>Adam G. Swiss</u> | | 23B. DATE SIGNED
<u>OCT 26, 1967</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>ADAM G. SWISS</u> | | 23D. ADDRESS
M.D. <u>6232 BELAIR ROAD BALTIMORE MD.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>10/28/67</u> | 24C. NAME of CEMETERY or CREMATORY
<u>Loudon Park Cemetery</u> | 24D. LOCATION (City, town, or county) (State)
<u>Frederick Rd. Balto, MD</u> |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 26 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | |
| 25C. FUNERAL DIRECTOR
<u>LEO G. COOK</u> | | ADDRESS
<u>7200 HARFORD RD.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------------|--|--------------------------------------|--|---|--|---|
| J-560 | | 67 10201 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10201 | |
| BIRTH NO. | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) JOYNER, PEARL (Pearlie) | | | | 2. DATE AND HOUR OF DEATH
10/23/67 4.35 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
LUTHERAN HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2801 RAYNER AVE. | | | |
| 5. SEX
F | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
5-24-1893 | 9. AGE (In years lost birthday)
74 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Birmingham, Alabama | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Anthony Williams | | | | 14. MOTHER'S MAIDEN NAME
UNK. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mr. Delmar Fisher 918 White lock st. | | |
| 18. 443 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
UREMIA
DUE TO

RENAL INSUFFICIENCY
DUE TO

HASCUD
DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH
DAYS

MONTHS

YEARS | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/31 19 67 to 10/23 19 67 , that (I) (we) lost saw the deceased alive on 10/23 19 67 and, that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
F. Queral | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/23/67 | |
| 23C. PHYSICIAN'S NAME (Type)
F. QUERAL | | | | 23D. ADDRESS
M.D. LUTHERAN HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-28-67 | | 24C. NAME of CEMETERY or CREMATORY
Mt. Calvary Cem. | | 24D. LOCATION (City, town, or county) (State)
A.A. Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 26 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
Morton E. Dye | | ADDRESS
H.F.H. 1701 Laurens | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|------------------|---|---|--|--|--|--|--|--|
| 67 10202 CERTIFICATE OF DEATH | | | | | Registered No. 67 10202 | | | | |
| BIRTH NO. 67 10202 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) McNeal, Robert Lee (McNiel) | | | | | 2. DATE AND HOUR OF DEATH
10/24/67 11:45 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
University Hosp. Balt. Md. | | | | | A. STATE Maryland B. COUNTY Baltimore | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 1703 N. Calhoun St. | | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 4/8/1911 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown | | 10B. KIND OF BUSINESS OR INDUSTRY unknown | | 11. BIRTHPLACE (State or foreign country) S. Carolina, York Co. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Robert McNeal, Sr. | | | | 14. MOTHER'S MAIDEN NAME Irene Straton | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown | | | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT ADDRESS Dr. Carrie McNiel 1703 Calhoun | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Cardiac arrest
Respiratory distress | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 10/22/67 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal signs | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (This hospital) attended the deceased from 10/21/67 to 10/24/67 that (I) (we) last saw the deceased alive on 24 Oct 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE A. J. Oldroyd | | | | | | 23B. DATE SIGNED 10/24/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) A. J. Oldroyd | | | | | | 23D. ADDRESS UNIV. HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 10-28-67 | | 24C. NAME OF CEMETERY or CREMATORY Jerusalem Bapt. Ch. Cem. | | 24D. LOCATION (City, town, or county) (State) Clover S.C. | | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 26 1967 | | | 25B. NAME OF REGISTRAR Robert E. Jackson | | | 25C. FUNERAL DIRECTOR ADDRESS Morton E. Dyett F.H. 1701 LAURENS | | | |

B-300

67 10203 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10203

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS

BETHEA

2. DATE AND HOUR PRONOUNCED DEAD

October 22, 1967

10:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1015 Aisquith St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1015 Aisquith Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

5-20-1910

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Julian Bethea

14. MOTHER'S MAIDEN NAME

Bell Jenkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

243-26-4175

17. INFORMANT

Savannah Bethea

ADDRESS

Lumberton

18.

4221

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

10/25/67

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

No

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/22/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

10/25/67

23C. NAME of CEMETERY or CREMATORY

Sandy Grove

23D. LOCATION

Lumberton

(City, town, or county)

N.C.

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 26 1967

24B. NAME OF REGISTRAR

Robert E. Fink

24C. FUNERAL DIRECTOR

McMillan's Funeral Home

ADDRESS

Lumberton

WILLIAM ROGGE

Carlington Phillips

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10204 | |
|--|-------------------------|--|--|---|---|
| BIRTH NO. 67 10204 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) DESHIELDS, Novella | | 2. DATE AND HOUR OF DEATH
10/22/67 9:45 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
The Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location)
1014 Sterling St. STIRLING ST | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
11/9/10 | 9. AGE (In years last birthday)
57 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Balt. Md. | |
| 13. FATHER'S NAME
James Stokes | | | 14. MOTHER'S MAIDEN NAME
Alice Ealen | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes 33996 675 | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Robert Deshields 1014 Stirling St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebrovascular accident. | | CAUSE OF DEATH
(A) Cerebrovascular accident.
(B) HASCD
(C) | | INTERVAL BETWEEN ONSET AND DEATH
13 hours ± 20 years | |
| 19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(1) Possible pneumonia (M.S.A.S) (2) Rheumatic heart disease (3) pulm. hypertension (4) pulm. edema | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 10/22/67 19 to 10/22 19 67 , that (I) (we) last saw the deceased alive on 10/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Elizabeth H. Jansson M.D. | | | | 23B. DATE SIGNED
10/23/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Elizabeth H. Jansson | | 23D. ADDRESS
M.D. Coleman Med. Service, Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/27/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Balt. National | |
| 24D. LOCATION (City, town, or county) (State)
5501 Enderwick Rd | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 26 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fairbank | | 25C. FUNERAL DIRECTOR
Joseph B. Locks Jr 1304 N. Central Ave | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|--|---|---|
| BIRTH NO. J-525 67 10205 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10205 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED
(Type or Print) Lucille Johnson | | |
| 2. DATE AND HOUR OF DEATH
Oct. 23, 1967 5¹⁰ A.M. | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
University of Maryland Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 4-02
D. STREET ADDRESS (If rural, give location) 689 W Mulberry St | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
1/23/41 | 9. AGE (In years last birthday)
26 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U S A | | 13. FATHER'S NAME
? | | 14. MOTHER'S MAIDEN NAME
Mary Johnson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs Hayden, same | |
| 18. 491X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Aspiration Pneumonia | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO
Convulsive Disorder | | INTERVAL BETWEEN ONSET AND DEATH
24-48 hrs.
4 yrs. | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Acute Diarrhea of unknown cause | | 12 hrs. | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
No | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 10/22 1967 to 10/23 1967 , that (I) (we) last saw the deceased alive on 10/23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
R.H. Anderson | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/23/67 | |
| 23C. PHYSICIAN'S NAME (Type)
R. H. Anderson | | 23D. ADDRESS
University of Maryland Hospital Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/28/67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
A A County Md | | 25A. DATE RECEIVED BY HEALTH DEPT.
OCT 26 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
A Halstead 1206 W North Ave | | | |
| 25D. ADDRESS | | | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------|---|------------------------------------|---|---|
| BIRTH NO.
67 10206 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10206 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) Martha Cassell Thompson | | 2. DATE AND HOUR OF DEATH
Oct. 21, 1967 2 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
3100 Wyman Park Drive | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE DC
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Washington
D. STREET ADDRESS (If rural, give location)
3633 - 18th Street NE | | | |
| 5. SEX
F | 6. RACE
Col | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Div. | 8. DATE OF BIRTH
9/26/25 | 9. AGE (In years last birthday)
42 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Architect
draftsman | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
DC | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Albert R. Cassell | | 14. MOTHER'S MAIDEN NAME
Martha Mason | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
494-34-2440 | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
Carcinomatous
Malignant melanoma | | INTERVAL BETWEEN ONSET AND DEATH
1 yr ?
15 yrs. | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug. 3 19 67 to Oct. 21 19 67 , that (I) (we) last saw the deceased alive on Oct. 22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
N. H. Puckham, M.D.
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
10/23/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Norman H. Puckham, Surgeon (R)
M.D. | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10/27/67 | | 24C. NAME of CEMETERY or CREMATORY
LINCOLN MEM. CEMETERY | |
| 24D. LOCATION
SUITLAND, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
10/20/1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Robert E. Taylor | | 25D. ADDRESS
1820 9th St., N.W.
WASHINGTON, D.C. | |

Government
Mellquist Nelson

R. H. Jackson

Chas. H. Jackson

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELIZABETH CHARLOTTA VICCHIO

VICCHIO

2. DATE AND HOUR PRONOUNCED DEAD

October 24, 1967

4:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1309 ~~Demarcay Way~~ Demarcay Way 21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

1/19/58

9. AGE (In years
last birthday)

9

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Alfred J. Vicchio

14. MOTHER'S MAIDEN NAME

Elaine S. Birx

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mr. Alfred J. Vicchio, 452 W. 23rd St. 21211

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A)

Multiple Traumatic Injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

6500 block O'Donnell St. 26-05

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

10/24/67 3:45 P. m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/25/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/27/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION

(City, town, or county)

Baltimore

Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 26 1967

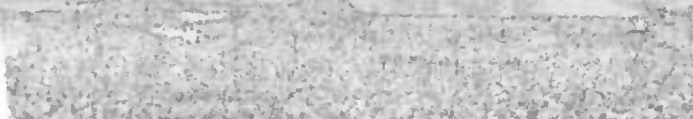
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS



67

CONFIDENTIAL

SECRET

TOP SECRET

SECRET

CONFIDENTIAL

SECRET

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SARA SENA

R.

COX

2. DATE AND HOUR PRONOUNCED DEAD

October 24, 1967

10:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4021 Greenmount Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

351 E. 1st St. 500 E. 41st Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

7/25/16

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerical Worker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Andy R. Cox

14. MOTHER'S MAIDEN NAME

Rosie S. Holdaway

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/24/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/27/67

23C. NAME OF CEMETERY or CREMATORY

Grubbs Chapel Cemetery

23D. LOCATION (City, town, or county) (State)

Independence

/ Grayson County, Virginia

24A. DATE REC'D BY HEALTH DEPT.

OCT 26 1967

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229

Virginia

March 10, 1900

Dear Mr. [unclear]

[unclear]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

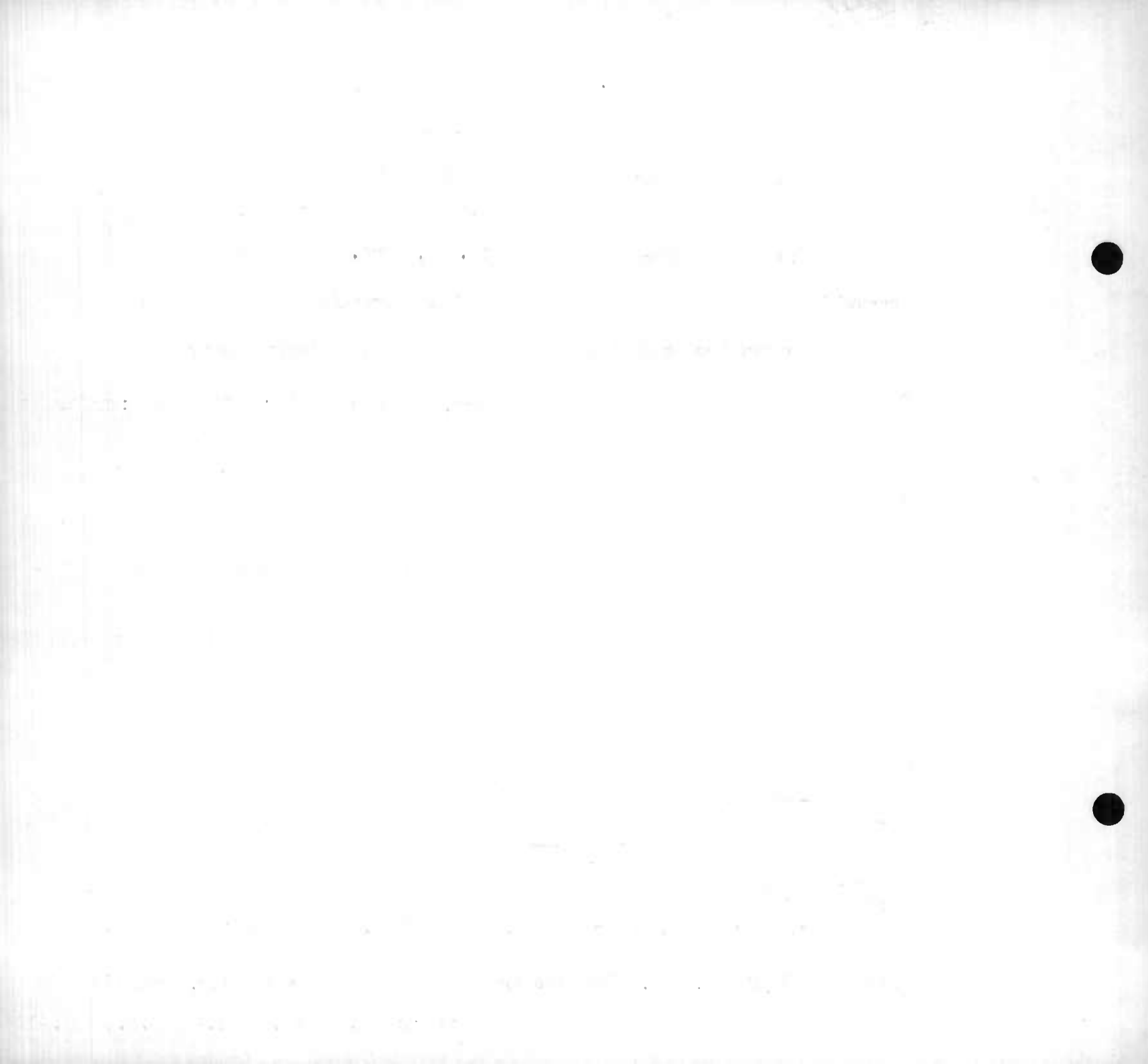
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10209 | |
|--|------------------|--|-----------------------------------|--|--|
| BIRTH NO. 67 10209 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) HERBERT E. HOFSTETTER | | 2. DATE AND HOUR OF DEATH
Oct. 26, 1967 3:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland
B. COUNTY Baltimore | | | |
| 3312 Lerch Drive...14 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 27-03
D. STREET ADDRESS (If rural, give location)
3312 Lerch Drive...14 | | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
Jan. 26, 1895 | 9. AGE (In years lost birthday)
72 ; | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Supt. - retired | | 10B. KIND OF BUSINESS OR INDUSTRY
Revere Copper & Brass | | 11. BIRTHPLACE (State or foreign country)
Rome, New York | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Em ile Hofstetter | | 14. MOTHER'S MAIDEN NAME
Elizabeth Knott | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW1 | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mrs. H.E. Hofstetter - 3312 Lerch Drive | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO malignant myeloma & giant cell osteosarcoma
(B) DUE TO leukemia & carcinoma
(C) ... | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1960 to Oct 26 1967, that (I) (we) last saw the deceased alive on Oct 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dr. Donald W. Mintzer | | M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/26/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Donald W. Mintzer | | 23D. ADDRESS
M.D. 3009 Evergreen Ave., Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/30/67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cemetery | |
| 24D. LOCATION
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 26 1967 | | | |
| 25B. NAME OF REGISTRAR
R. E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
Leonard J. Ruck, Inc. - Balto., Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|---|--|--|
| BIRTH NO. 5-370 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10210 | |
| M.E. CASE NO. | | 67 10210 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | MELVIE H. STEELE | | 2. DATE AND HOUR OF DEATH
Oct. 25, 1967 11:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
Maryland | | | |
| 7224 Old Harford Road | | C. CITY OR TOWN
Baltimore | | | |
| | | D. STREET ADDRESS
(If rural, give location)
7224 Old Harford Rd., | | | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
Jan. 16, 1898. | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
West Virginia | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Robert Lee McCormick | | | 14. MOTHER'S MAIDEN NAME
Vienna Dunbar | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Codine Lewis: 7224 Old Harford Rd | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Cardiac decompensation. 5 yr.
(B) Arterio-sclerotic Heart disease. 5 yr.
(C) Senile arterio-sclerosis. 5 yr. | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus. 15 yr. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (was) attended the deceased from 7/10 1963 to 10/25 1967, that (I) (was) lost saw the deceased alive on 10/17 1967 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | | | 23B. DATE SIGNED
10/26/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Norman R. Freeman, Jr. | | 23D. ADDRESS
11 W. 29th St., Balto, Md.-21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/29/67. | | 24C. NAME of CEMETERY or CREMATORY
Mt. Zion Cemetery | |
| 24D. LOCATION
Waiteville, West Virginia | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 26 1967 | | | |
| 25B. NAME OF REGISTRAR
R. E. Farley | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc.-Balto., Md.-14 | | | |

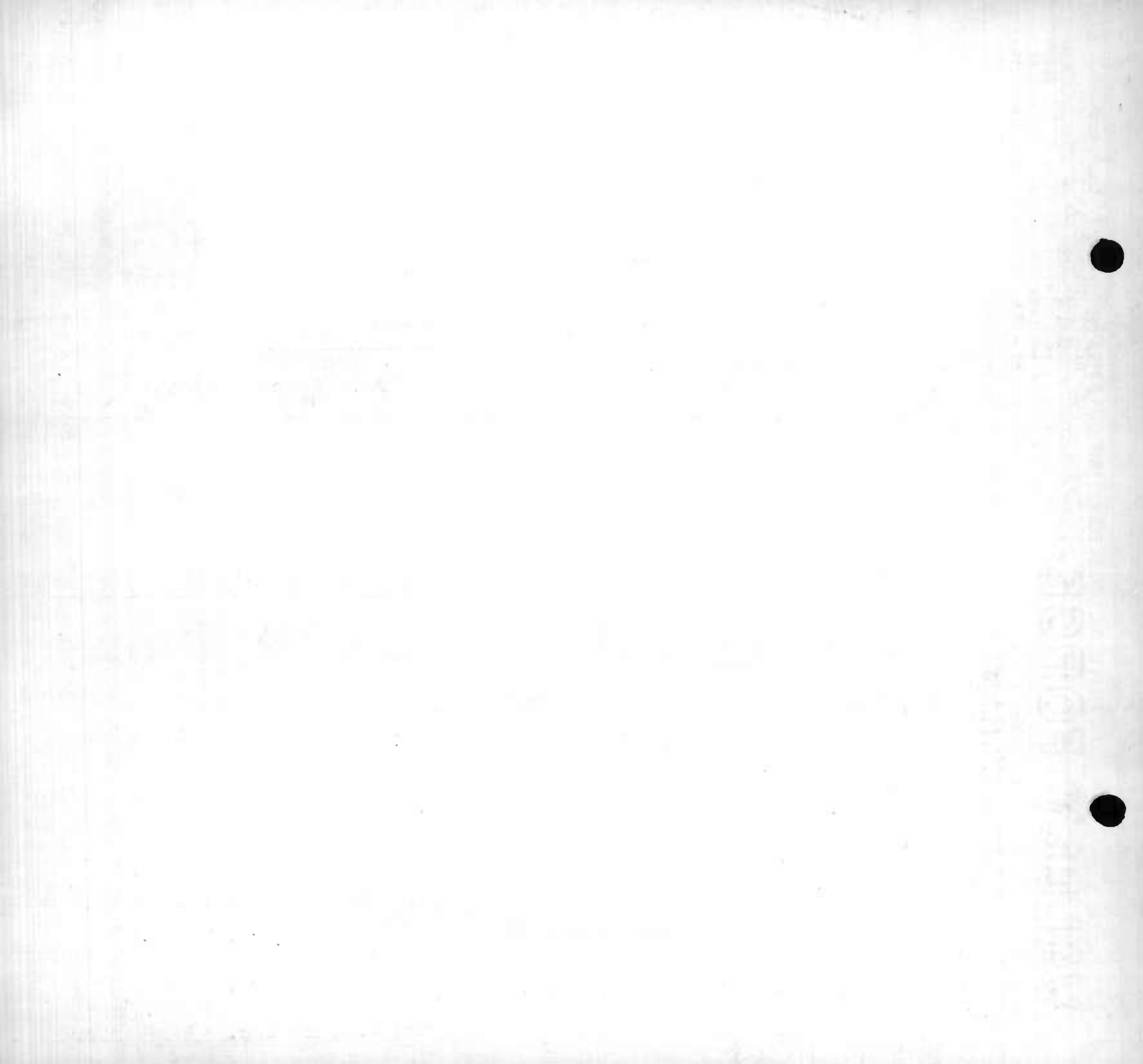


TO BE APPROVED BY MEDICAL EXAMINER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

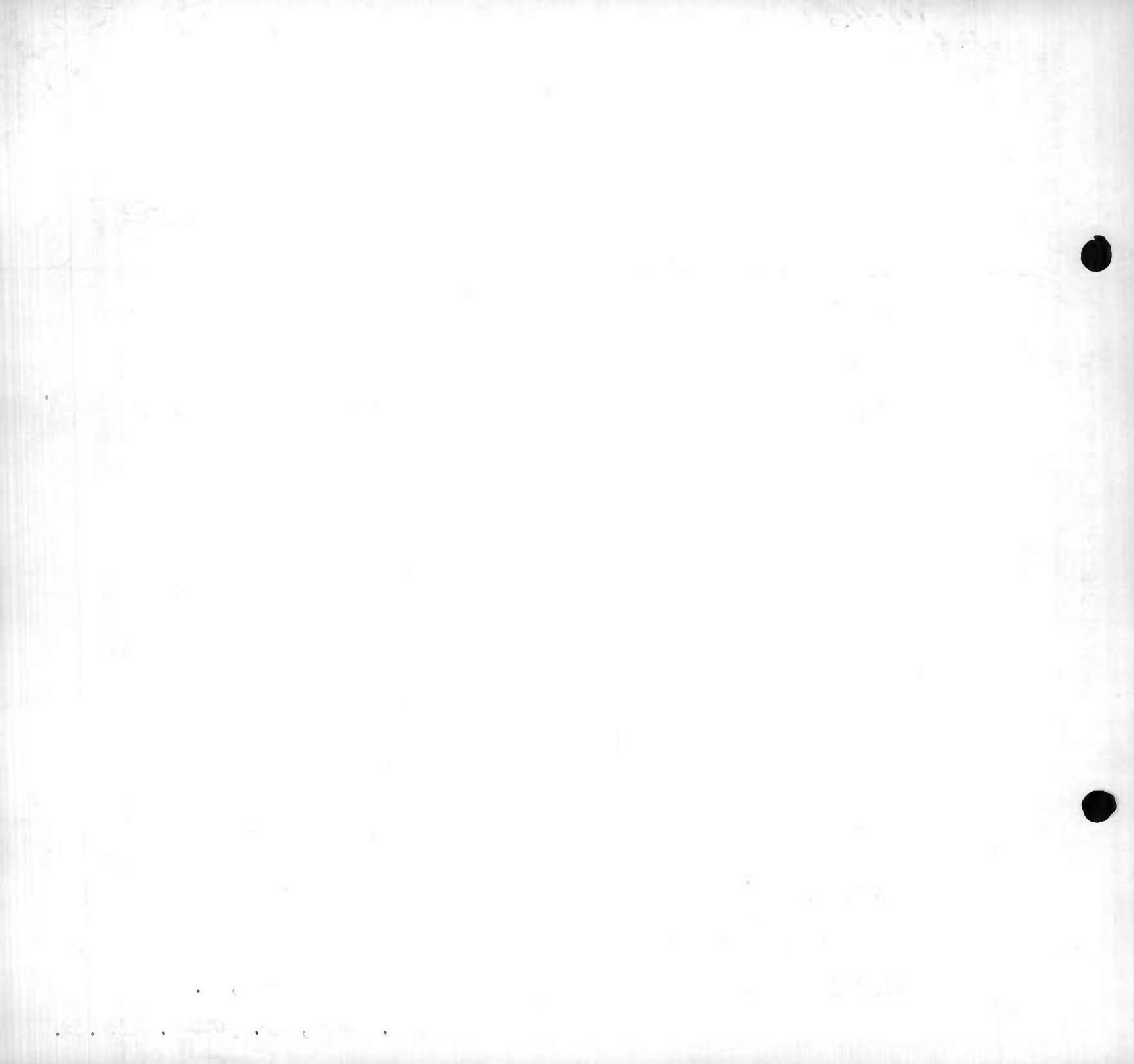
| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. 67 10211 | | 67 10211 | | 67 10211 | |
| M.E. CASE NO. | | NAME OF DECEASED (Type or Print) JOSEPH HILARY LEGGETT | | 2. DATE AND HOUR OF DEATH OCTOBER 26/67 3:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY | | 5. SEX M 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL BALTIMORE, MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) 2019 E. 30th ST. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (Ret) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 13. FATHER'S NAME S. ALBERT LEGGETT | | 14. MOTHER'S MAIDEN NAME Mamie F. Trageser | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI | | 16. SOCIAL SECURITY NO. 918-18-4776 | | 17. INFORMANT Mrs. Violet Leggett - Same ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Pneumonia (B) Sepsis due to decubitus ulcer, buttock (C) Fracture, femur (D) Atherosclerotic cardiovascular heart disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 09-5-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURE OF FEMUR | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2019 E. 30th ST. BALTIMORE | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) AUG-29-1967 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Patient fell while walking to bathroom | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 2, 1967 to OCTOBER 26, 1967, that (I) (we) last saw the deceased alive on OCTOBER 26, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ruben V. Luna | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 10-26-67 | |
| 23C. PHYSICIAN'S NAME (Type) RUBEN V. LUNA | | 23D. ADDRESS M.D. FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10/30/67 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cem. | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 26 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. | |
| 25D. ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|---|--|---|
| BIRTH NO. M-460 | | 67 10212 CERTIFICATE OF DEATH | | Registered No. 67 10212 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) MARY E MAULER | | | 10-25-67 8:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
MERCY HOSPITAL | | | A. STATE MARYLAND
B. COUNTY BALTO | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 33-00 | | |
| | | | D. STREET ADDRESS (If rural, give location)
7145 EAST BROOK AVE | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
9-3-95 | 9. AGE (In years last birthday)
82 | 10. Under 1 Yr. Months: Days
11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
FRANK ENLEY | | | 14. MOTHER'S MAIDEN NAME
ROSEMARY MURPHY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Mrs Florence Anderson |
| | | | ADDRESS
7145 Eastbrook Ave. | | |
| 18. 420.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cerebrovascular accident, thrombosis, RT | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) Upper gastrointestinal bleeding probably from peptic ulcer
(B) Hypertensive Heart Disease
(C) Arteriosclerotic Heart Disease | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) + | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 24 1967 to Oct 25 1967 , that (I) (we) last saw the deceased alive on Oct 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Maria Y. Que | | | | 23B. DATE SIGNED
10/25/67 | |
| 23C. PHYSICIAN'S NAME (Type)
MARIA Y. QUE | | | | 23D. ADDRESS
MERCY HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/28/67 | | 24C. NAME OF CEMETERY or CREMATORY
Parkwood Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 26 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
John A. Moran, Inc. | |
| | | | | ADDRESS
3000 E. Balto. St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>67 10213</u> | |
| BIRTH NO. <u>R-163</u> | | 67 10213 | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>John A. Ruppert</u> | | <u>Oct. 25, 1967</u> <u>3</u> <u>A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>3000 Barclay Street</u> | | A. STATE <u>Maryland</u>
B. COUNTY | |
| 5. SEX <u>M</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | |
| 6. RACE <u>W</u> | | D. STREET ADDRESS (If rural, give location)
<u>3000 Barclay Street</u> | |
| 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widowed</u> | | B. DATE OF BIRTH
<u>8/14/1898</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Unknown</u> | | 9. AGE (In years last birthday)
<u>69</u> | |
| 10B. KIND OF BUSINESS OR INDUSTRY
<u>Glenn L. Martin Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Germany</u> | |
| 13. FATHER'S NAME
<u>Unknown</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | |
| 16. SOCIAL SECURITY NO.
<u>212-10-9962A</u> | | 17. INFORMANT
<u>Mrs. Marie Creighton</u> | |
| 18. <u>154X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>Carcinoma of Rectum</u> | | ADDRESS
<u>3005 Barclay St</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 yr.</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Oct 166</u> to <u>Oct 19 67</u> , that (I) (we) last saw the deceased alive on <u>Oct 24 19 67</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<u>Sheldon Goldgeier</u> M.D. | | 23B. DATE SIGNED
<u>Oct 26, 1967</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>SHELDON GOLDGEIER</u> M.D. | | 23D. ADDRESS
<u>848 W 36'S T.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>10/28/67</u> | |
| 24C. NAME OF CEMETERY or CREMATORY
<u>Holy Redeemer Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 26 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | |
| 25C. FUNERAL DIRECTOR
<u>John A. Moran, Inc.</u> | | ADDRESS
<u>3000 E. Baltimore St.</u> | |

Government of Boston
1/2

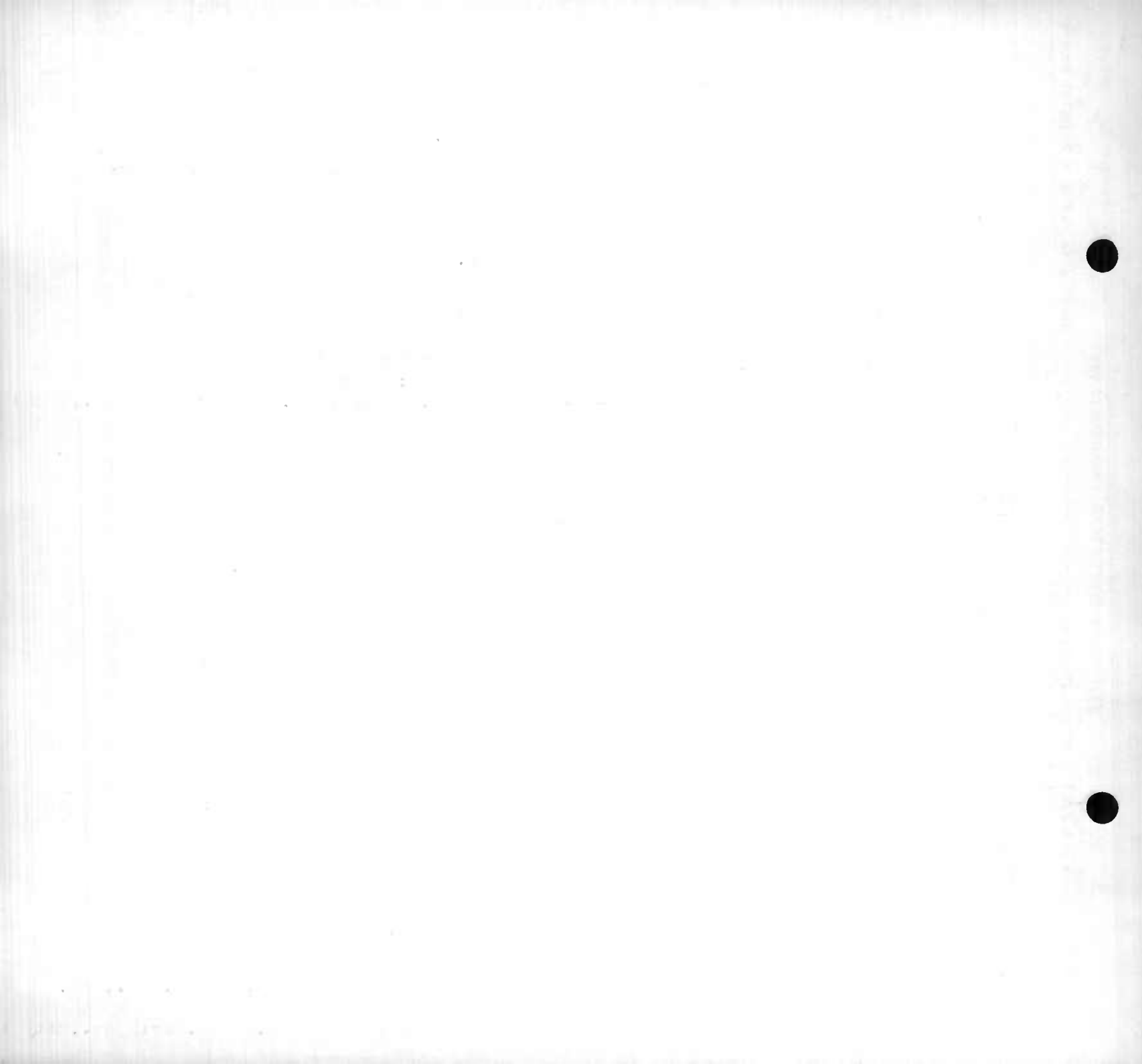
Sheldon Forster
848 W 32nd St
New York, N.Y.
Oct 24 1942

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10214 | |
| L-165
67 10214 | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| ELEANOR LEVERING | | 10-25-67 11 am M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION

Bolton Hill Nursing Home | | A. STATE
MD. | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore City | |
| | | D. STREET ADDRESS (If rural, give location)
ALTAMONT HOTEL - 1215 Entaw Pl | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
Dec. 26, 1876 |
| | | 9. AGE (In years lost birthday)
90 | 10. CITIZEN OF WHAT COUNTRY?
Baltimore City |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 13. FATHER'S NAME
Richard Baron | | 14. MOTHER'S MAIDEN NAME
Catherine McElroy | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
J1 213-50-6911 | |
| | | 17. INFORMANT: Nephew
John F. Davies, Jr. 1504 Dunlora Rd., 21204 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
430.01
BRONCHOPNEUMONIA | | CAUSE OF DEATH
(A) DUE TO
INTERCOURSE
(B) DUE TO
PREMENSTRUAL TOXEMIA | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH
Ca. 1 wk | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10 years 19 to Oct. 25 1967, and that (I) (we) last saw the deceased alive on 16 Oct 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Louis P. Hamburger Jr. | | 23B. DATE SIGNED
10/26/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Louis P. Hamburger Jr. | | 23D. ADDRESS
1001 St Paul St Baltimore Md 21202 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/27/67 | |
| 24C. NAME OF CEMETERY or CREMATORY
Druid Ridge Cemetery | | 24D. LOCATION (City, town, or county) (State)
Pkesville, Balto. Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 26 1967 | | 25B. NAME OF REGISTRAR
Robert E. Finkbeiner | |
| 25C. FUNERAL DIRECTOR
STEWART & MOWEN CO. | | 25D. ADDRESS
108 W. North Av., City 1 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|-------------------------|---|--------------------------------------|---|---|
| C-400 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10215 | |
| BIRTH NO. 67 10215 | | 67 10215 | | 67 10215 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Frank Cowley</i> | | 2. DATE AND HOUR OF DEATH
<i>10-24-67 17:10 P. M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>23-02</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore #21230</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>South Baltimore General Hosp.</i> | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location)
<i>1313 Marshall St.</i> | |
| 5. SEX
<i>M.</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Widowed</i> | 8. DATE OF BIRTH
<i>1-17-1897</i> | 9. AGE (in years lost birthday)
<i>70</i> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>NONE</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Illinois</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
<i>William Cowley</i> | | 14. MOTHER'S MAIDEN NAME
<i>Jennie Anderson</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>345-07-0806</i> | | 17. INFORMANT ADDRESS
<i>Miss Nadine B. Cowley, 1313 Marshall St.</i> | |
| 18. <i>420.11</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>Myocardial infarction, acute</i>
DUE TO
(B) <i>Coronary insufficiency, acute</i>
DUE TO
(C) <i>Arteriosclerotic cardiovascular disease</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>48 1/2 hours</i>
<i>Undetermined</i>
<i>Undetermined</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>YES.</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (at) (this hospital) attended the deceased from <i>10-22</i> 19 <i>67</i> to <i>10-24</i> 19 <i>67</i> , that (at) (we) last saw the deceased alive on <i>10-24</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>John Albert Bighee</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>10-25-67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>John Albert Bighee</i> | | 23D. ADDRESS
<i>1213 Light St.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>10-28-67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Holy Cross Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Ritchie Hwy. A. A. Co., Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>Oct 26 1967</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>Flynn & Fleming 1422 Light St.</i> | | | |

Handwritten text, likely bleed-through from the reverse side of the page. The text is faint and mostly illegible due to fading and the quality of the scan.

Handwritten text at the bottom right of the page, possibly a signature or a date. It is also faint and difficult to decipher.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------------------|---|-------------------------------------|--|---|--|--|
| BIRTH NO. 67-20965 67 10216 | | CERTIFICATE OF DEATH | | Baltimore City Health Department | | Registered No. 67 10216 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) BOY MOORE ANDRE ROBERT | | 2. DATE AND HOUR OF DEATH
10/19/67 3³⁰ A | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
LUTHERAN HOSPITAL OF MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | D. STREET ADDRESS (If rural, give location)
4002 FAIRVIEW AVENUE | |
| 5. SEX
M | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
10/17/67 | 9. AGE (In years lost birthday)
2 dan | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
USA Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HAROLD MOORE | | | | 14. MOTHER'S MAIDEN NAME
Johnson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MOORE SANDRO | | ADDRESS
SAME AS ABOVE | |
| 18. 776X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

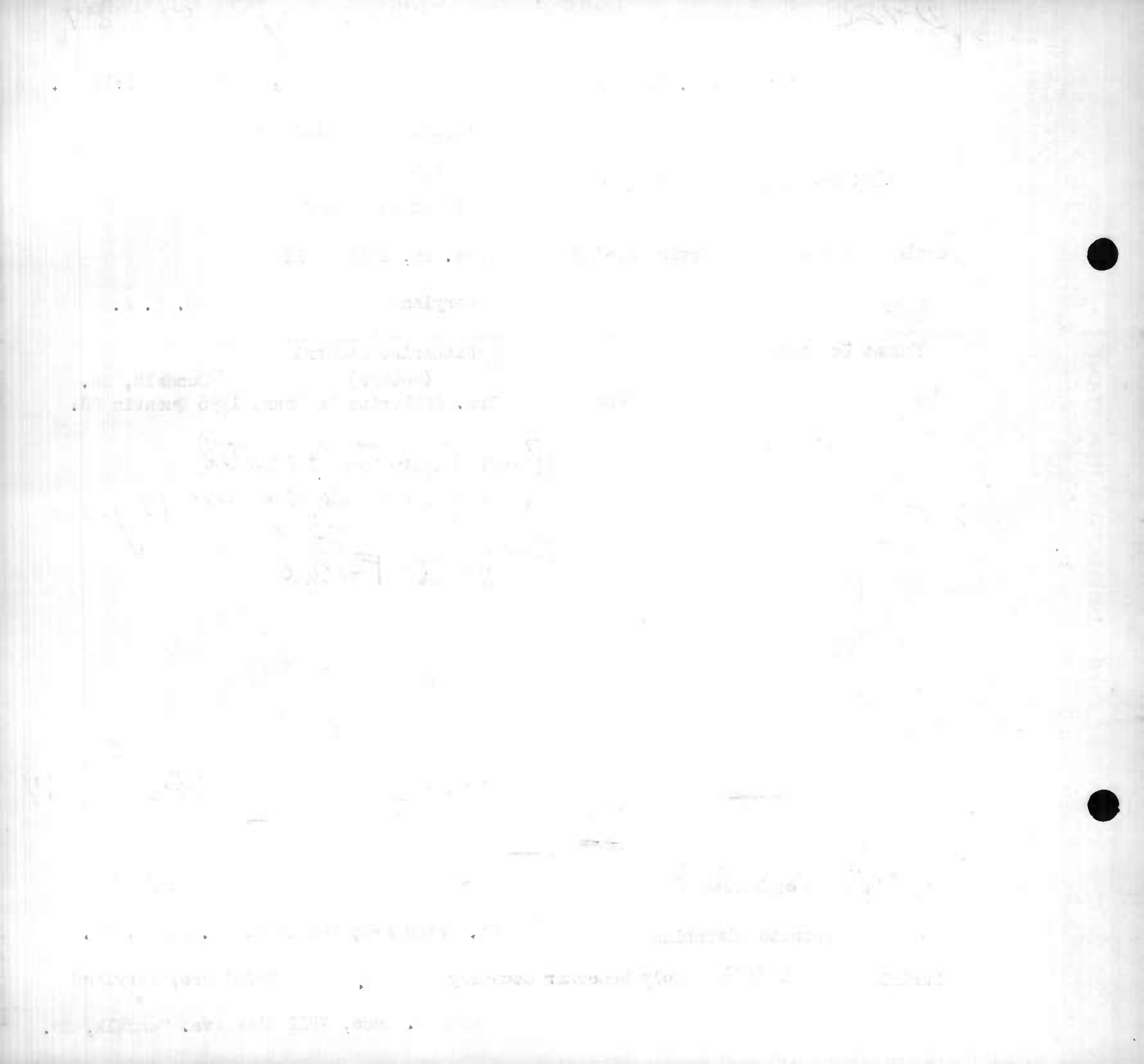
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) PREMATURITY
DUE TO
(B) DUE TO
(C) | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
10/19/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/17/67 to 10/19/67 , that (I) (we) lost saw the deceased alive on 10/19/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
V. Biswanath Pillai | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/19/67 | |
| 23C. PHYSICIAN'S NAME (Type)
N. BISWANATH PILLAI | | M.D. | | 23D. ADDRESS
730 ASHBURTON STREET | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/23/67 | | 24C. NAME of CEMETERY or CREMATORY
Balti National | | 24D. LOCATION (City, town, or county) (State)
Balti City | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | 25B. NAME OF REGISTRAR
R. E. Taylor | | 25C. FUNERAL DIRECTOR
L. H. Brown + Son | | ADDRESS
123 W. Montgomery St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10217 | |
|--|-------------------------|--|---|---|--|
| D-120
67 10217 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | Charmaine K. De Vaux | | October 24, 1967 1:17 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Baltimore City Hospital (DOA) | | A. STATE
Maryland | | B. COUNTY
Baltimore | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Dundalk | | | |
| | | D. STREET ADDRESS (If rural, give location)
1956 Quentin Road | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married | 8. DATE OF BIRTH
Sept. 25, 1955 | 9. AGE (In years last birthday)
12 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
Thomas De Vaux | | 14. MOTHER'S MAIDEN NAME
Katherine Stewart | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT (Mother) Dundalk, Md.
Mrs. Katherine De Vaux, 1956 Quentin Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
7-57-5 I | | CAUSE OF DEATH
(A) DUE TO
Severe Cyanotic Congenital Heart Disease with Progenies
(B) DUE TO
Cardiac Enlargement
(C) Heart Failure | | INTERVAL BETWEEN ONSET AND DEATH
12 years | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the deceased) attended the deceased from 1964 to October 19 67 , that (I) (we) last saw the deceased alive on October 20 19 67 and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) (the deceased) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Joseette Bianchine</i> | | | | 23B. DATE SIGNED
10/24/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Josette Bianchine | | | | 23D. ADDRESS
M.D. Ft. Meade Army Hospital, Ft. Meade, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/27/67 | | 24C. NAME of CEMETERY or CREMATORY
Meadowridge Memorial Park Cem. | |
| 24D. LOCATION
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10218 | |
|--|--|--|--|--|--|
| 67 10218 | | | | BIRTH NO. | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | |
| (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | |
| 44 Union Memorial Hosp. | | Md., Balt. City | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| D. STREET ADDRESS | | (If rural, give location) | | 12-01 | |
| 3601 Greenway | | Baltimore | | 12-01 | |
| 5. SEX | | 6. RACE | | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (Specify) | |
| F | | W | | MARRIED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| Housewife | | MARRIED | | 04/21/03 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| Henry Hesselman | | Clara ? Wheeler | | 64 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | 212-01-7293 | | Mr. James N. Carney | |
| 18. 420.0 I | | CAUSE OF DEATH | | ADDRESS | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Congestive heart failure | | Same | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (B) due to arteriosclerotic heart | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (C) disease | | Dr. Cpen | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initialed medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/03/67 to 10/24/67. | | 23A. SIGNATURE | | 23B. DATE SIGNED | |
| that (I) (we) lost saw the deceased alive on 10/24/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | B. J. Weckesser | | 10/24/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 24A. BURIAL CREMATION, REMOVAL (Specify) | |
| BARRY J. WECKESSER M.D. | | THE UNION MEMORIAL HOSPITAL | | Burial | |
| 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 10/27/67 | | Druid Ridge Cemetery | | Pikesville, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| OCT 27 1967 | | Robert E. Finkbeiner | | Wm. V. Pickney & Sons North & Pa. Aves. | |

Correct (page 2)

Review Memorial
H-29

F W

Henry Messelman

10/20
10/20
10/20

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04/21/03
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Maryland
Clara

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U.S.

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B. J. Wickman

10/24

10/24

10/24

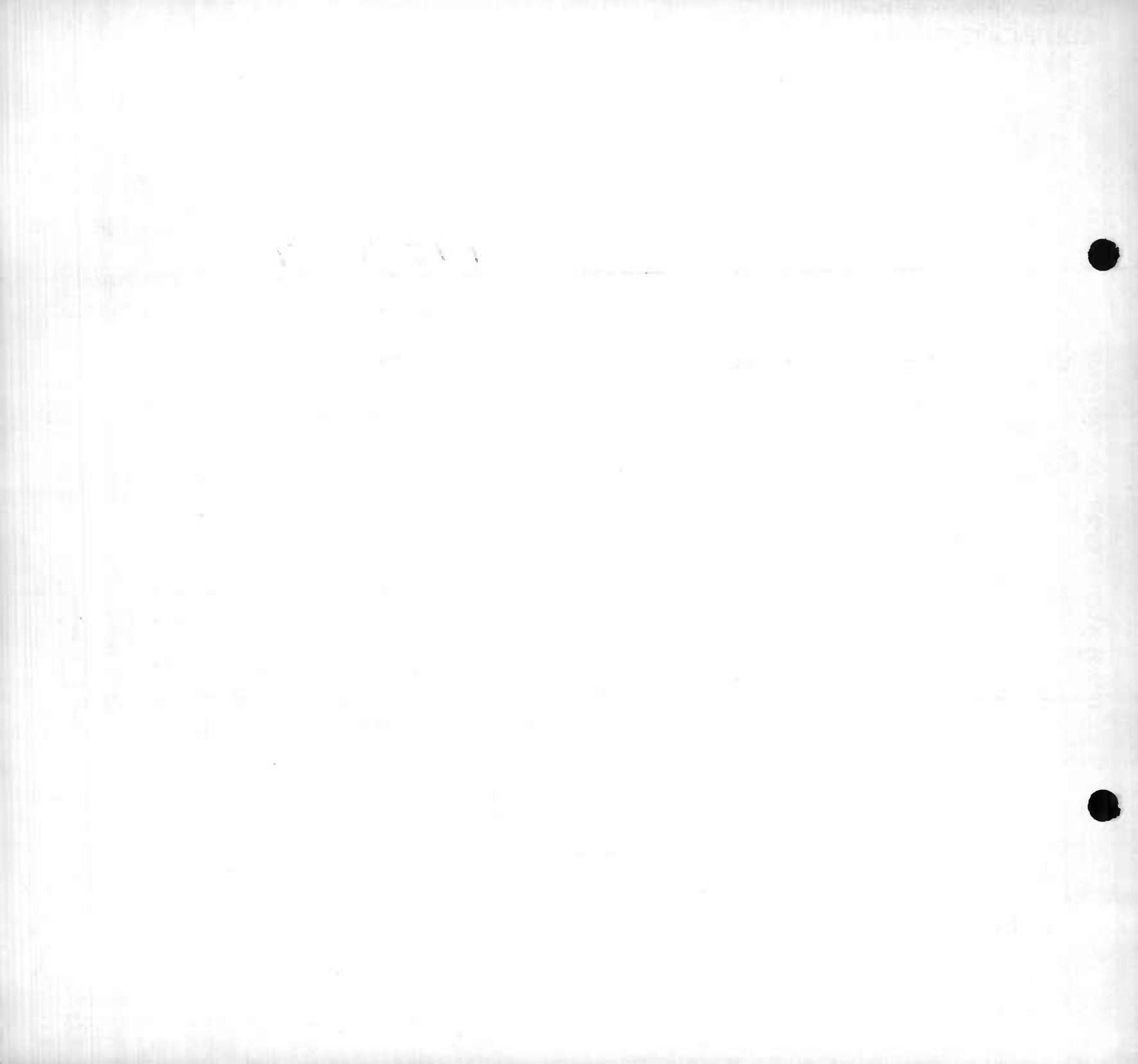
10/24

Review Memorial
H-29

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10219 | |
|---|---------------------|--|-------------------------------------|--|--|
| BIRTH NO. 67 10219 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) SWEREN, Rebecca | | 2. DATE AND HOUR OF DEATH
10-26-67 6.30 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SINAI HOSPITAL | | A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
3821 FRANKDALE AVE | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
10-15-87 | 9. AGE (In years lost birthday)
79 | II Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Rev. CHARLES | | 14. MOTHER'S MAIDEN NAME
CLARA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Ruben Sweren 6204 GREENSPRING AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
pulmonary edema. | | CAUSE OF DEATH
(A) DUE TO
congestive heart failure
(B) DUE TO
arteriosclerotic cardiovascular disease
(C) fracture of left hip. | | INTERVAL BETWEEN ONSET AND DEATH
24h.
10 years.
9-28-67 | |
| 19A. DATE OF OPERATION
9-29-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Fr. left hip. | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Milford Manor Nursing Home. | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
patient fell on the floor | |
| 21D. TIME OF INJURY (APPROX.)
9-28-67 6:45 PM | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
patient fell on the floor | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-28-67 to 10-26-1967 , that (I) (we) last saw the deceased alive on 10-26-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
[Signature] | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10-26-67 | |
| 23C. PHYSICIAN'S NAME (Type)
FRANCISCO SAENZ M.D. | | 23D. ADDRESS
Sinai Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/27/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Rosedale | |
| 24D. LOCATION
Balto | | (City, town, or county) (State)
md | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
OCT 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Sylvan S. Livingston, INC | |
| ADDRESS
Gwynn | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------------------|--|--|--|--|
| BIRTH NO. 67 10220 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10220 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Minnie H. Boyd | | | 2. DATE AND HOUR OF DEATH
October 23, 1967 9⁴⁵ P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
House in the Pines- Belvedere | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
121 N. Lakewood Ave | | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed | 8. DATE OF BIRTH
Feb. 17, 1888 | 9. AGE (in years last birthday)
79 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
wrapper | | 10B. KIND OF BUSINESS OR INDUSTRY
Hoschild-Kohn | 11. BIRTHPLACE (State or foreign country)
Baltimore Md | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Louis Huether | | | 14. MOTHER'S MAIDEN NAME
Katherine Burkheimer | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
216-03-4559 | 17. INFORMANT
Mrs. Catherine E. Zucher, 6702 Chisholm Rd | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Leukemia, Acute | | | INTERVAL BETWEEN ONSET AND DEATH
10 years or LONGER | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic Pyelonephritis, Chronic Biliary Disease, Chronic Cholelithiasis, Chronic Pancreatitis, Hypertension, Diabetes Mellitus | | |
| 19A. DATE OF OPERATION
10/23/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/8 1959 to 10/23 1967 , that (I) (we) last saw the deceased alive on 10/23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
JEANNETTE R. HEGHINIAN, M.D. | | | 23B. DATE SIGNED
10/24/67 | | |
| 23C. PHYSICIAN'S NAME (Type)
JEANNETTE R. HEGHINIAN, M.D. | | | 23D. ADDRESS
2212 South Road, BALTIMORE, MD 21209 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
Oct. 25, 67 | 24C. NAME OF CEMETERY or CREMATOR
Baltimore | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Strong Byers | |
| | | | | ADDRESS
8728 Liberty Rd Randallstown Md | |

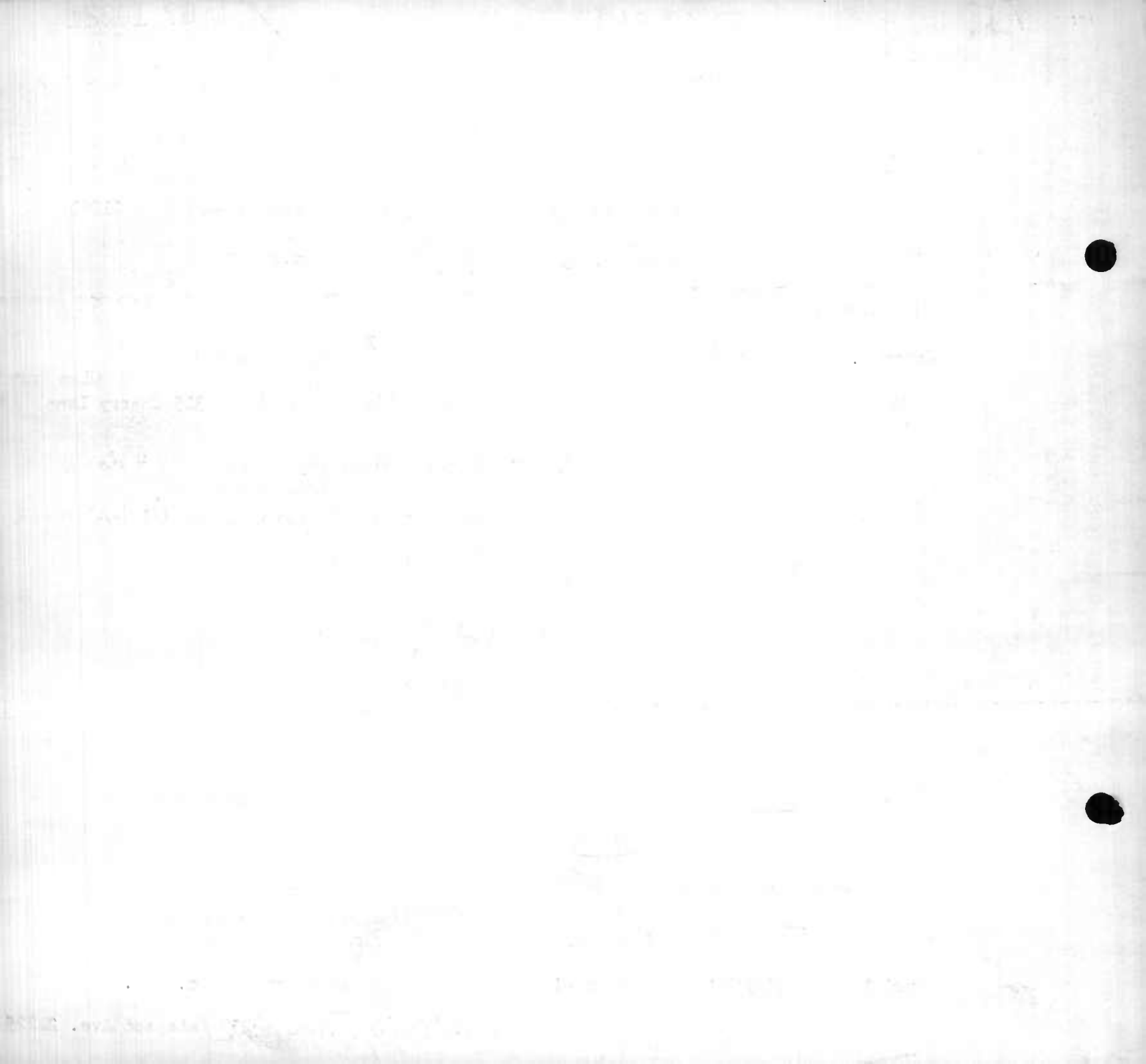
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|------------------------------|---|--|
| <div style="display: flex; justify-content: space-between;"> 14-543 67 10221 BALTIMORE CITY HEALTH DEPARTMENT Registered No. <u>67 10221</u> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> | | | |
| BIRTH NO. _____
M.E. CASE NO. _____
1. NAME OF DECEASED (Type or Print) <u>BLANCHE Edna HAMLEN</u> | | 2. DATE AND HOUR OF DEATH
<u>October 25 1967 11:55 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>UNIVERSITY HOSPITAL</u>
<u>BALTIMORE, MARYLAND</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>ANNE ARUNDEL</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>GLEN BURNIE</u> <u>52-00</u>
D. STREET ADDRESS (If rural, give location)
<u>325 CHERRY LANE</u> <u>21061</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>Caucasian</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>10/14/90</u> |
| 9. AGE (In years last birthday)
<u>77</u> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
_____ | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
_____ | |
| 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | |
| 13. FATHER'S NAME
<u>James B. Woodward</u> | | 14. MOTHER'S MAIDEN NAME
<u>Rosella Lowrey</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO. _____ | |
| 17. INFORMANT
<u>Hamilton Hamlin</u> | | ADDRESS <u>Glen Burnie 325 Cherry Lane</u> | |
| 18. <u>260X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>AT PROBABLE ACUTE MYOCARDIAL INFARCTION</u>
DUE TO
(B) <u>ATHEROSCLEROTIC HEART DISEASE</u>
DUE TO
(C) <u>? Diabetes Mellitus</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Diabetes Mellitus</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>at least 4 yrs</u> | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
_____ | |
| 20A. AUTOPSY? (Yes or No)
<u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
_____ | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
_____ | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
_____ | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
_____ | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
_____ | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 24</u> 19 <u>67</u> to <u>Oct 25</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ((I) (We) (did)) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<u>John F. Rogers</u> | | 23B. DATE SIGNED
_____ | |
| 23C. PHYSICIAN'S NAME (Type)
<u>John F. Rogers</u> | | 23D. ADDRESS
<u>UNIVERSITY HOSPITAL</u>
<u>BALTIMORE, MARYLAND</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>10/30/67</u> | 24C. NAME OF CEMETERY or CREMATORY
<u>Cedar Hill</u> | 24D. LOCATION (City, town, or county) (State)
<u>Anne Arundel Co. Md.</u> |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 27 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Jackson</u> | |
| 25C. FUNERAL DIRECTOR
<u>McCully Funeral Home</u> | | ADDRESS
<u>Patapsco Ave. 21225</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|---|--|---|--|
| 67 10222 | | 67 10222 | | 67 10222 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | John A. Mox | | 10/25/67 8:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | Md. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| 916 Lennon St. | | Baltimore | | 18-03 | |
| D. STREET ADDRESS (If rural, give location) | | 916 Lennon St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Male | White | Married | 2/2/1900 | 67 | Sheerman |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| Burch Window Co. | | Maryland | U.S.A. | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| John Mox | | Anna Chopak | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | |
| no | | 215-10-6835 | Mrs. Nellie Mox | 916 Lennon St. | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) DUE TO | | Immediate | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) DUE TO | | 10 years - | |
| ANTECEDENT CAUSES | | (C) DUE TO | | 10 years - | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Coronary insufficiency | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1956 to Oct. 25 1967, that (I) (we) last saw the deceased alive on Oct. 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Charles Commesello M.D. | | | | Oct 26/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Charles Commesello | | M.D. 910 W. Lombard St. Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 10/28/67 | New Cathedral Cem | 4300 Old Frederick Rd. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| OCT 27 1967 | Robert E. Faldut | John J. Commesello Inc. | | 23rd St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------|---|-----------------------------------|---|--|
| BIRTH NO. 67 10223 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10223 | |
| 1. NAME OF DECEASED
(Type or Print) SAMUEL Z. SOCOLAR
<i>Socolar Samuel</i> | | 2. DATE AND HOUR OF DEATH
10-23-67 5 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
CERTIFICATE AMENDED
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL
(If not in hospital or institution, give street address or location) 10-30-67 | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) MARYLAND
D. STREET ADDRESS (If rural, give location) * 7031 ALDEN ROAD #21208 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED NEVER MARRIED
MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 1-10-1894 | 9. AGE (In years last birthday) 72-73 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL | | 10B. KIND OF BUSINESS OR INDUSTRY GROCER | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME MORDECAI SOCOLAR | | 14. MOTHER'S MAIDEN NAME ZELDA WASSERMAN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 219-32-1307A | | 17. INFORMANT ADDRESS MRS. SARAH SOCOLAR, 7031 ALDEN ROAD #21208 | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO acute myocardial infarction.
(B) DUE TO C.H.F.
(C) coronary insufficiency atherosclerotic cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH 16. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) — | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? 2.10 PM 5 PM | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-23-67 to 10-23-67 , that (I) (we) last saw the deceased alive on 10-23-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Sany | | | | 23B. DATE SIGNED 10-23-67 | |
| 23C. PHYSICIAN'S NAME (Type) Francis Sany | | | | 23D. ADDRESS Sinai Hospital H. D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 10-25-67 | | 24C. NAME OF CEMETERY or CREMATORY SWINICHER WOLINER BENEVOLENT | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. Oct 25 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD | | | |

FUNERAL DIRECTOR: IMPORTANT

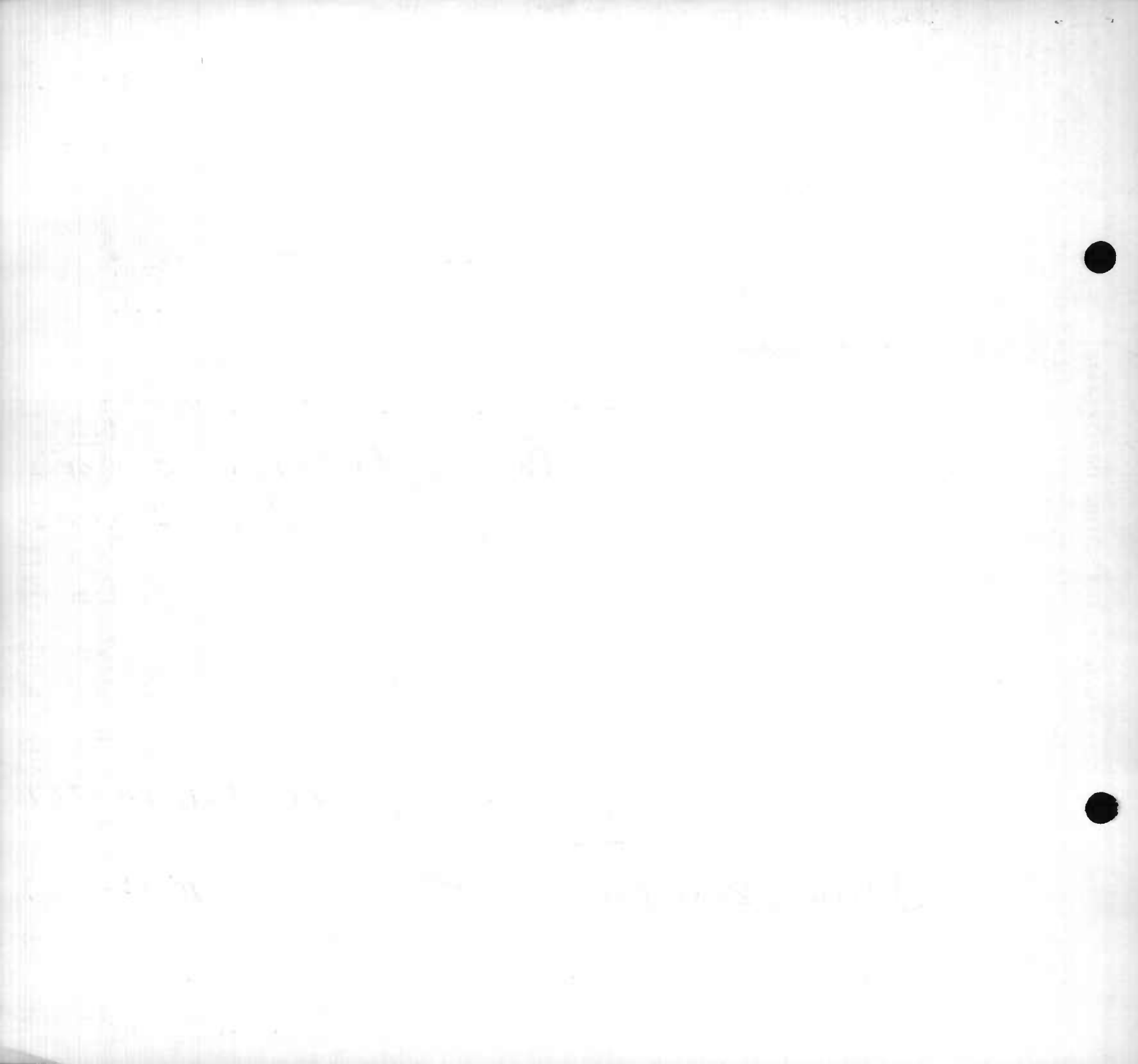
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10224 | |
|--|---|---|---|---|--|
| <div style="font-size: 1.5em; font-weight: bold;">C-432</div> <div style="font-size: 1.5em; font-weight: bold;">67 10224</div> | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. 67 10224 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) HARRY GOLDSCHIEDER | |
| 2. DATE AND HOUR OF DEATH
OCTOBER 24, 1967 12:03 A.M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2804 REISTERSTOWN ROAD | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2804 REISTERSTOWN ROAD | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
9-5-1890 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PROPRIETOR | | 10B. KIND OF BUSINESS OR INDUSTRY
REAL ESTATE | | 11. BIRTHPLACE (State or foreign country)
AUSTRIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
BAER GOLDSCHIEDER | | 14. MOTHER'S MAIDEN NAME
? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
220-54-6782 | | 17. INFORMANT
MR. DAVID V. GOLDSCHIEDER, 2442 FOREST GREEN RD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Coronary Occlusion
DUE TO
arteriosclerosis of coronaries
(B) 5 weeks
DUE TO
5 years
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 12 1951 to Oct 24 1967, that (I) (we) last saw the deceased alive on Oct 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Irvin Sauber | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10-24-67 | |
| 23C. PHYSICIAN'S NAME (Type)
IRVIN SAUBER | | 23D. ADDRESS
M.D. 6905 PARK HEIGHTS AVENUE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-25-67 | | 24C. NAME OF CEMETERY or CREMATORY
BNAI JACOB | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | | |
| 25B. NAME OF REGISTRAR
R. E. FALKENBERG | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD | | | |



FUNERAL DIRECTOR: IMPORTANT

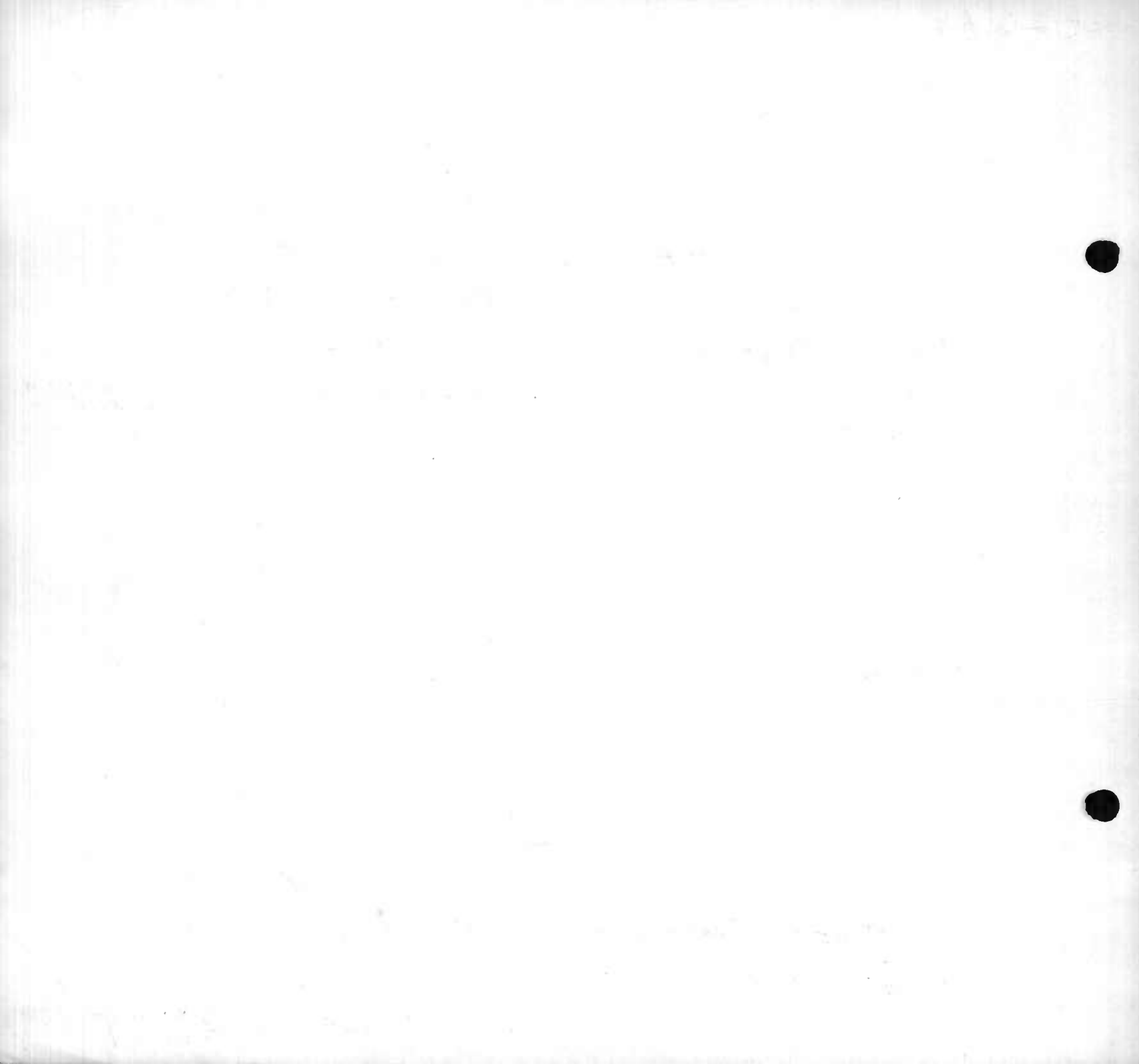
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| A-141 | | 67 10225 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10225 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Ida Applefeld | | Oct. 24 / 67 7:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Belvedere Nursing Home
W. Belvedere Ave | | | | A. STATE
B. COUNTY
Maryland
C. CITY OR TOWN
Baltimore
D. STREET ADDRESS
4726 Rathland Ave. | | | |
| 5. SEX
Female | | 6. RACE
White | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed | | 8. DATE OF BIRTH
March 15, 1888 | |
| 9. AGE (In years lost birthday)
79 | | 10. UNDER 1 Yr. Months Days | | 11. UNDER 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
at home | | 11. BIRTHPLACE (State or foreign country)
Austria | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Samuel Isidorstein | | | | 14. MOTHER'S MAIDEN NAME
Esther ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Dr. Willard Applefeld - 6207 Park Heights Ave | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) CARDIO-Respiratory Failure
DUE TO
Congestive Heart Failure
(B) Atherosclerotic C.U.T.
DUE TO
(C) Pneumonitis | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 7 1940 to Oct 24 1967, that (I) (we) last saw the deceased alive on Oct 24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Willard Applefeld | | | | 23B. DATE SIGNED
10/24/67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Willard Applefeld | | | | 23D. ADDRESS
5901 Park Heights Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Oct 25/67 | | 24C. NAME OF CEMETERY or CREMATORY
Hebrew Friendship | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
Sol Lennan & Son - 6010 Rust Rd. | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|----------------------|---|----------------------------|---|----------------------------|---|--|
| BIRTH NO. | | 67 10226 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10226 | |
| M.E. CASE NO. | | | | 2-326 | | | |
| 1. NAME OF DECEASED
(Type or Print)
MRS. CATHERINE E. LEYDECKER | | | | 2. DATE AND HOUR OF DEATH
OCTOBER 24, 1967 3:35 AM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
BOW SECOURS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
Maryland - Baltimore Co. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore Co. 53-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
8 Edmondson Ridge Rd. | | | |
| 5. SEX
FEMALE | 6. RACE
CAUCASIAN | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
1-3-99 | 9. AGE (In years lost birthday)
68 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND, BALTO. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Rance Myers | | | | 14. MOTHER'S MAIDEN NAME
Lillian Gladhour | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-10-4826A | | 17. INFORMANT
ESTELLE E. Leydecker | | ADDRESS
8 Edmondson Ridge Rd BALTO 28MD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Coronary insufficiency | | | | CAUSE OF DEATH
(A) DUE TO
Gangrene, left leg
(B) DUE TO
Saddle embolus, bifurcation of aorta
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
None | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
H | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from OCTOBER 17 1967 to October 24 1967, that (I) (we) last saw the deceased alive on October 24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type)
Mehdi SARKARATI | | | | | | 23B. DATE SIGNED
October 24, 1967 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10/28/67 | | 24C. NAME of CEMETERY or CREMATORY
Louden PK Cem | | 24D. LOCATION (City, town, or county) (State)
BALTO. 29 MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
E. H. MacTalb | | ADDRESS
301 Frederick Rd BALTO MD | |



48-19-12

ME

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|--|--|--|
| BIRTH NO. B-600 67 10227 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10227 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Lee V. Berry | | | 2. DATE AND HOUR OF DEATH
October 27, 1967 3:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND | | | A. STATE md. B. COUNTY Baltimore | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location)
1423 Tennant Way 21224 | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
12-13-92 | 9. AGE (In years lost birthday)
74 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Plant operator | | 10B. KIND OF BUSINESS OR INDUSTRY
Sand & Gravel | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | |
| 13. FATHER'S NAME
Will Berry | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 14. MOTHER'S MAIDEN NAME
Alphie Sisk | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS
RECORDS: BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE MD. 21224 | | |
| 18. 493X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)
Pneumonia | | | CAUSE OF DEATH
(A) DUE TO
(B) Chronic Obstructive Pulm. disease
(C) years | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Urinary tract Infection 3 weeks | | | INTERVAL BETWEEN ONSET AND DEATH
3 days | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
10/27/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that this hospital attended the deceased from October 23, 1967 to October 24, 1967 , that we lost saw the deceased alive on October 24, 1967 and that in our opinion death occurred on the date and hour and from the causes stated above. We did view the body after death. | | | | | |
| 23A. SIGNATURE
Neil R. Williamson
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
October 24, 1967 | |
| 23C. PHYSICIAN'S NAME (Typed)
NEIL WILLIAMSON | | | | 23D. ADDRESS
4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/27/67 | | 24C. NAME of CEMETERY or CREMATORY
Bethel Church Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Culpepper, Va. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fisk | | 25C. FUNERAL DIRECTOR ADDRESS
Ullrich Funeral Home 4210 Belair Rd. | |
| For Clore Funeral Home, Culpepper, Va. | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|-------------------------|---|---|---|--|
| BIRTH NO. 67 10228 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10228 | |
| 1. NAME OF DECEASED
(Type or Print) DAVIS, AUDREY W. | | | 2. DATE AND HOUR OF DEATH
OCTOBER 22, 1967 10:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
ST. AGNES HOSPITAL
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
WILKENS & CATON AVES.
BALTIMORE, MD. 21229 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY HOWARD
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
ELLCOTT CITY 21043
D. STREET ADDRESS (If rural, give location)
38 ALLVIEW DRIVE | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
10-03-93 | 9. AGE (In years lost birthday)
74 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Doctor SEC. | | | 10B. KIND OF BUSINESS OR INDUSTRY
SECURITAI | | 11. BIRTHPLACE (State or foreign country)
MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
GEORGE W. DEC'D | | |
| 14. MOTHER'S MAIDEN NAME
FLORENCE (BROWNLEY) DEC'D | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | |
| 16. SOCIAL SECURITY NO.
212-07-9121 | | | 17. INFORMANT
WILKENS & CATON AVES
ST. AGNES RECORDS BALTIMORE, MD. 21229 | | |
| 18. 3-4-3X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
G-I HEMORRHAGE
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
HEMORRHAGIC GASTRITIS | | | INTERVAL BETWEEN ONSET AND DEATH
DAYS | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCTOBER 20, 1967 to OCTOBER 22, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on OCTOBER 22, 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 23A. SIGNATURE
Michael E. Pelezar | | | | 23B. DATE SIGNED
10/22/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Michael E. Pelezar, | | | | 23D. ADDRESS
WILKENS & CATON AVE
ST. AGNES HOSPITAL-BALTO., MD. 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-25-67 | | 24C. NAME OF CEMETERY or CREMATORY
St John's | |
| 24D. LOCATION (City, town, or county) (State)
ELLCOTT CITY MD | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. F... | | 25C. FUNERAL DIRECTOR
John P. Black | | | |

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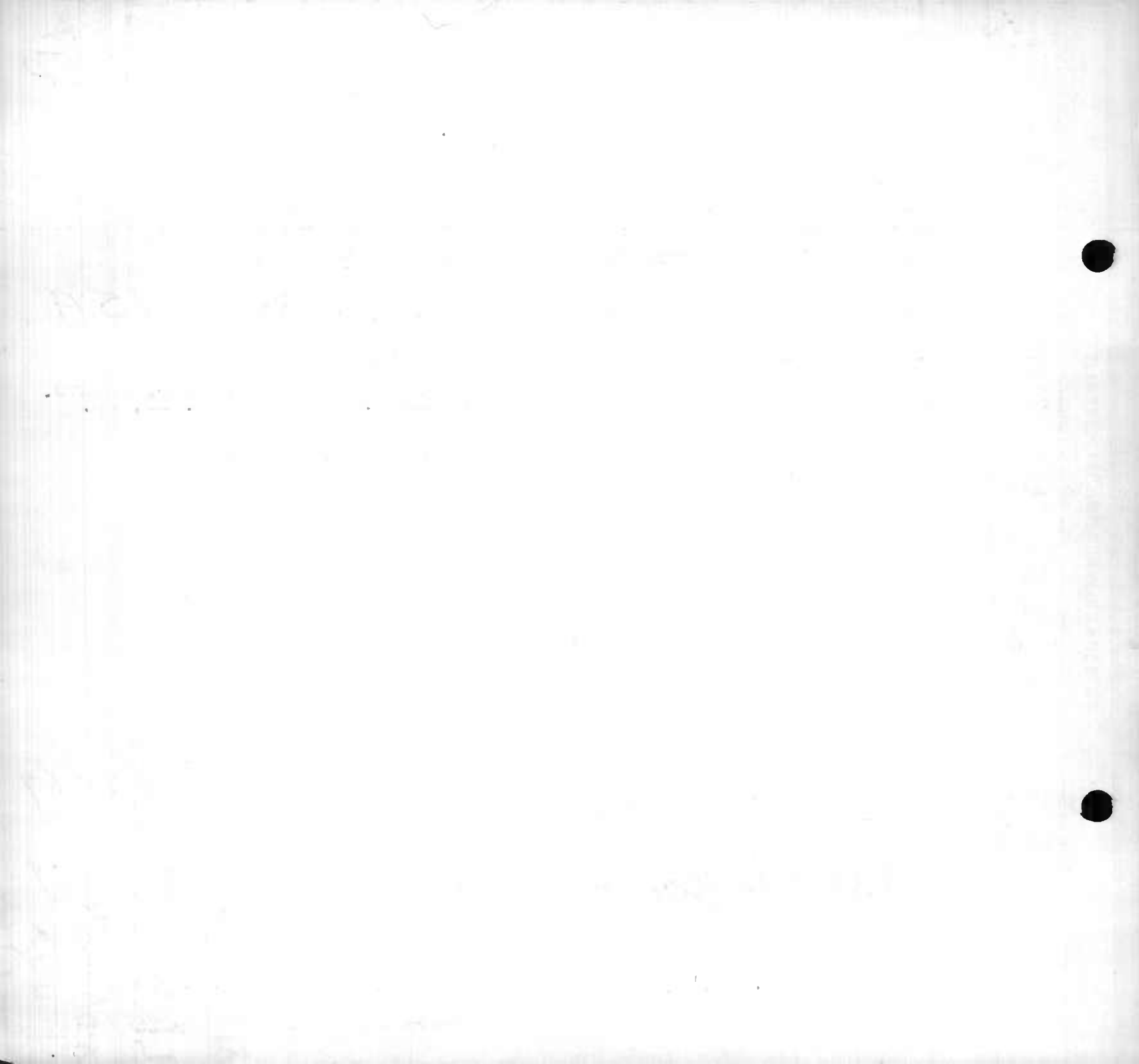
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

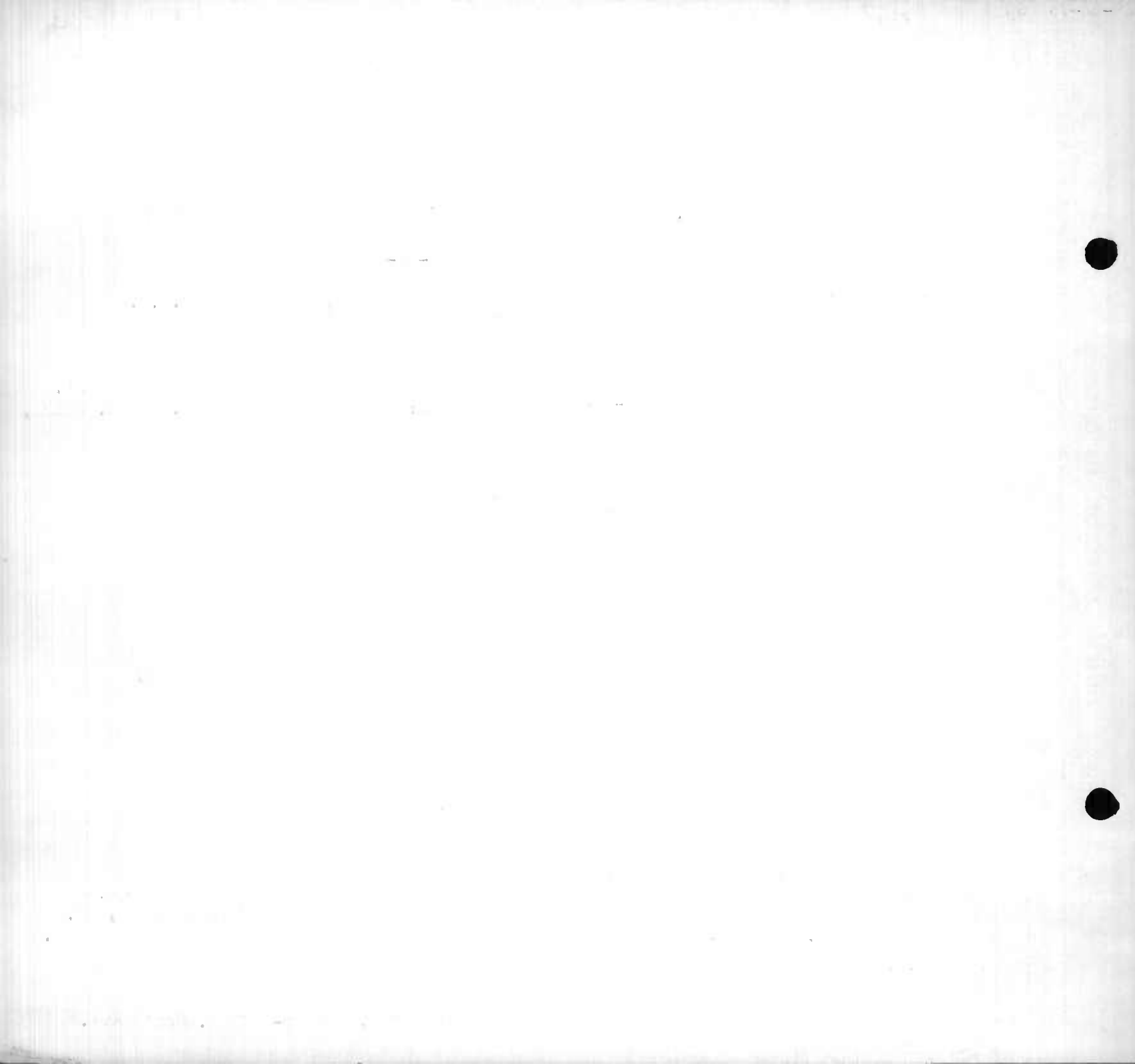
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|--|-----------------------------------|--|-------------------------------|--|---|
| BIRTH NO. 67 10229 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10229 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 25 Oct 1967 6:57 P.M. | |
| 1. NAME OF DECEASED
(Type or Print) Margaret Tuttle | | 2. DATE AND HOUR OF DEATH | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Md. | | B. COUNTY | |
| 90 Hill Crest Nursing Home
212 Stoney Run Lane | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore 20-05 | |
| D. STREET ADDRESS (If rural, give location) | | 2204 Wilkens Avenue | | | |
| 5. SEX F | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married | 8. DATE OF BIRTH OCT 27, 1883 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| Housework | None | BALTIMORE, MD | U.S.A. | | |
| 13. FATHER'S NAME Thomas Tuttle | | 14. MOTHER'S MAIDEN NAME Catherine Crowe | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS 5309 Pembroke Ave. Balto. 10, Md. | |
| 18. 430.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, apnoea, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO Interspersclerosis | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES (B) DUE TO | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from that (I) (we) first saw the deceased alive on Oct 23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 1963 19 to Oct 25 67 | | | |
| 23A. SIGNATURE (Signature) | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 10-25-67 | |
| 23C. PHYSICIAN'S NAME (Type) Robert E. Finkbeiner | | 23D. ADDRESS 5006 Roland Ave - Balto 10, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Oct. 28, '67 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 24E. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker | | 24F. ADDRESS | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 27 1967 | | 25B. NAME OF REGISTRAR Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker | |
| 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------|--|------------------|--|--|--|--|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| G-650 67 10230 | | | | LINNIE V. GREEN | | 10/24/67 1 5 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MARYLAND | | | | MARYLAND
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2220 LINDEN AVENUE #21217 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
lost birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| FEMALE | NEGRO | MARRIED | 6-19-20 | 47 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | Home | | MARYLAND, Baltimore | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| PAUL EDWARDS | | | | LINNIE Broady | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | 117-22-2845 | | RECORDS: BCM 4940 EASTERN AVE. BALTO. 21224. | | MD. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO
(B) DUE TO
(C) Metastatic adenocarcinoma / yr
primary site Unknown | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2/67 | | Ca - Radical Hysterectomy | | YES | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 19 to 19 that (1) (we) last saw the deceased alive on 19 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| David E. McBeth M.D. | | | | 10/24/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| DR. DAVID E. MC BETH | | | | BALTIMORE 21224, MD.
BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 10/28/67 | | Mount Auburn Cemetery | | Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| OCT 27 1967 | | Herbert E. Nutter | | Herbert E. Nutter-3035 W. North Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

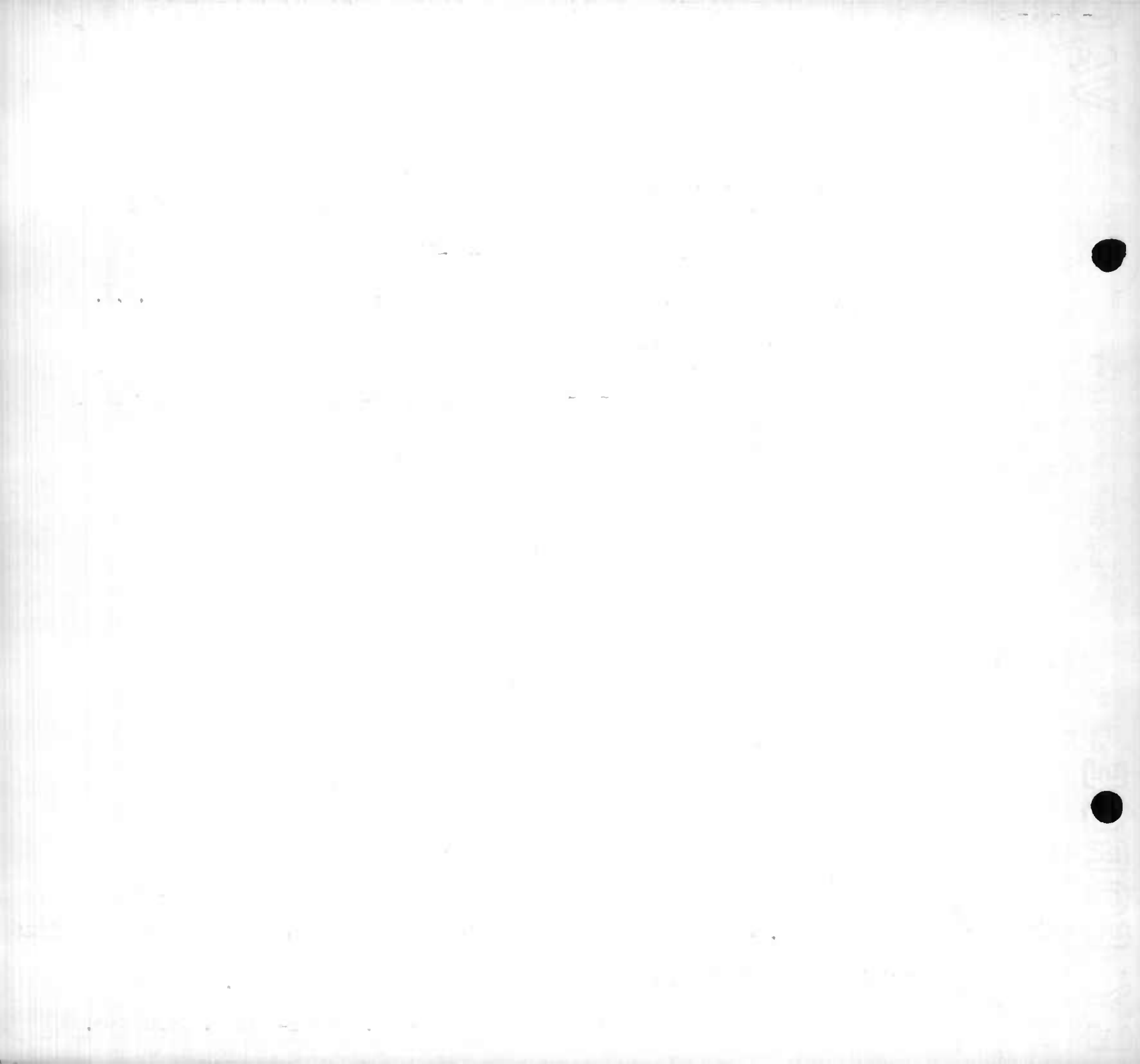
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10231 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10231 | |
|--|---------------------------|---|--|--|--|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) THOMAS CHARLES C. | | 2. DATE AND HOUR OF DEATH
10/22/67, 9:20 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 21216 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
LUTHERAN HOSPITAL OF MD. | | | | D. STREET ADDRESS (If rural, give location)
3401 GWYNNS FALLS PKY | | 15-48 | |
| 5. SEX
Male | 6. RACE
Colored | 7. MARRIED NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
FEB 3, 1908 | 9. AGE (In years last birthday)
59 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CHECK | | 10B. KIND OF BUSINESS OR INDUSTRY
NAVY DEPT | | 11. BIRTHPLACE (State or foreign country)
FEDERALSBURG, MD | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
CHARLES THOMAS | | | | 14. MOTHER'S MAIDEN NAME
MARY BOWSER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
214-248335 | | 17. INFORMANT
MRS. SELENA P. THOMAS | |
| 18. 443X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
HCVD, @ Cerebral Thrombosis
E @ Hemiplegia
ASCVD | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
PKY | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | | |
| | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
10/26/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Thankam B. Pillai | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
THANKAM B. PILLAI | | | | 23D. ADDRESS
LUTHERAN HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10/26/67 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE NATIONAL CEM. | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR
HERBERT F. NUTTEN | | | |
| | | | | ADDRESS
3035 W. NORTH AVE | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|--------------------------------------|---|---|
| P-324
BIRTH NO. 67-10232 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67-10232 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) CLARENCE Peticolas | | 2. DATE AND HOUR OF DEATH
10-20-67 11:40 AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
204 North Fulton Avenue 21223 | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
1-28-1898 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chauffeur | | 10B. KIND OF BUSINESS OR INDUSTRY
Davidson Transfere | | 11. BIRTHPLACE (State or foreign country)
Virginia, Chiles City | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Clarence Peticolas | | | |
| 14. MOTHER'S MAIDEN NAME
Nanny ? ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
212-12-5732 | | | |
| 16. SOCIAL SECURITY NO.
212-12-5732 | | 17. INFORMANT ADDRESS
Records: BCM-4940 Eastern Avenue 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Respiratory Arrest | | CAUSE OF DEATH
(A) DUE TO
Carcinoma of Lung
(B) DUE TO
Carcinoma Transverse Colon
(C) | | INTERVAL BETWEEN ONSET AND DEATH
5 min
Months | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 10-15 19 67 to 10-20 19 67 , that (1) (we) lost saw the deceased alive on 10-20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Robert A. Cordes | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10-20-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Robert A. Cordes | | 23D. ADDRESS
M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/24/67 | | 24C. NAME of CEMETERY or CREMATORY
Arbutus Memorial Park | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Co. Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | | |
| 25B. NAME OF REGISTRAR
Herbert E. Nutter | | 25C. FUNERAL DIRECTOR ADDRESS
Herbert E. Nutter-3035 W. North Ave. | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10233

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GLORIA May CAMPBELL

2. DATE AND HOUR PRONOUNCED DEAD

October 20, 1967 9:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2450 Etting Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

May 4, 1938

9. AGE (In years
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bar Maid

10B. KIND OF BUSINESS OR INDUSTRY

Package Goods

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Norman T. Campbell

14. MOTHER'S MAIDEN NAME

Lucille Haycock

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-38-5571

17. INFORMANT

ADDRESS

Mrs. Lucille Campbell 3108 Wylie Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wound of Chest Involving The
Heart and its major vessels, Lung
and Liver.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Dixieland Cafe

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2022 Edmondson Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
10/20/67 9:55 PM

21E. INJURY OCCURRED

WHILE AT WORK ☒NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Shot during at argument

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/21/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/25/67

23C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

23D. LOCATION

(City, town, or county)

Arbutus

Balto Co.

(State)
Md

24A. DATE REC'D BY HEALTH DEPT.

OCT 27 1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Herbert E. Nutter

ADDRESS

3035 W. North Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10234 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10234 | |
|---|--|--|--|--|---|--|-----------|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | CONTEE, Leon Sylvester | | | 2. DATE AND HOUR OF DEATH
October 25, 1967 | | 3:45 P M. |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| Veterans Administration Hospital | | 3900 Loch Raven Blvd
Baltimore, Maryland 21218 | | Maryland | | Charles | |
| 5. SEX
Male | | | | 6. RACE
Negro | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| Truckdriver | | U.S. Government | | 9/16/24 | | 43 | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| Maryland | | | | U.S.A. | | Thomas Contee | |
| 14. MOTHER'S MAIDEN NAME | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| Helen Jackson | | | | Yes 5/13/43 to 11/5/45 | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | |
| 577-20-5023 | | | | Records | | | |
| 18. CAUSE OF DEATH | | | | ADDRESS | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | VAH, Baltimore, Md. 21218 | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Hemorrhage from trachea | | | |
| ANTECEDENT CAUSES | | | | DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Carcinoma of esophagus | | | |
| | | | | DUE TO | | | |
| | | | | (C) | | | |
| II | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | 48 hours | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | | | yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (X) (this hospital) attended the deceased from October 24, 1967 to October 25, 1967, that (X) (we) last saw the deceased alive on October 25, 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| John L. Cameron, M.D. | | | | October 26, 1967 | | JOHN L. CAMERON | |
| 23D. ADDRESS | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) | | | |
| Veterans Administration Hospital | | | | Burial | | | |
| 3900 Loch Raven Blvd. Baltimore, Md. 21218 | | | | 24B. DATE | | | |
| | | | | 10/30/67 | | | |
| 24C. NAME of CEMETERY or CREMATORY | | | | 24D. LOCATION | | | |
| Saint Peter's Cemetery | | | | Waldorf, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| OCT 27 1967 | | | | Robert E. Farber, M.D. | | Adams Funeral Home Aquasco, Maryland | |

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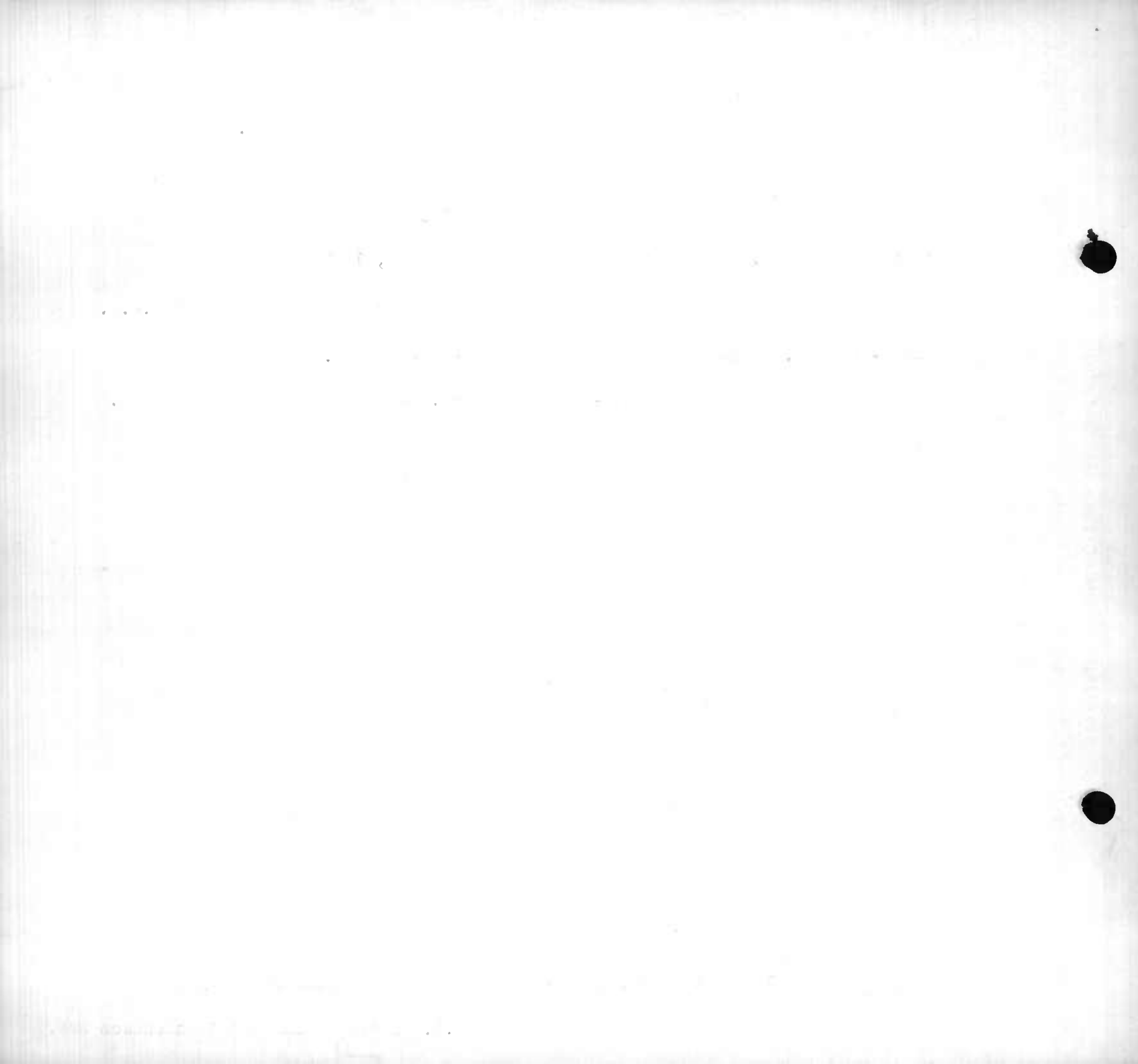
100

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10235 | |
|--|---------------|--|---------------------------------|--|---|
| BIRTH NO. 67 10235 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARY GERBIG | | 2. DATE AND HOUR OF DEATH 10-25-67 1:05 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY | | A. STATE Maryland B. COUNTY Balto. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 5105 Lodestone Way | | | |
| 5. SEX Female | 6. RACE Cauc. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH March 24, 1901 | 9. AGE (In years last birthday) 66 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME late- John C. Davis | | 14. MOTHER'S MAIDEN NAME late- Emma J. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 219-32-2205 | | 17. INFORMANT ADDRESS Mrs. John Russell 313 Lambeth Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) MYOCARDIAL INFARCTION DUE TO (B) ASCVD DUE TO (C) Diabetes Mellitus Gangrene of Feet. | | 7 hrs. 9 days ago | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 9/19 1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED attempted femoralopopliteal bypass | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 9-1-67 to 10/25-67, that (2) (we) last saw the deceased alive on 10/24-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. M. Barrash | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 10/25/67 | |
| 23C. PHYSICIAN'S NAME (Type) J. M. BARRASH | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10/28/67 | | 24C. NAME of CEMETERY or CREMATORY Lorraine Park | |
| 24D. LOCATION (City, town, or county) Baltimore Maryland | | 24E. STATE (State) Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 27 1967 | | 25B. NAME OF REGISTRAR R. E. F. F. F. | | 25C. FUNERAL DIRECTOR ADDRESS H.H. Witzke & Sons 4101 Edmondson Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10236 | |
|---|--|---|--|---|--|
| 67 10236 | | | | BIRTH NO. | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) MARY AGNES TAYLOR | |
| 2. DATE AND HOUR OF DEATH
10/24/67 1 4³⁰ P.M. | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 16-08 | |
| D. STREET ADDRESS (If rural, give location)
624 N. HILTON ST. | | | | 5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | |
| 8. DATE OF BIRTH
9/29/73 | | 9. AGE (In years last birthday) 94 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 11. BIRTHPLACE (State or foreign country)
VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
CHARLES WHITLOCK | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | ADDRESS | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Myocardial Infarction
INTERVAL BETWEEN ONSET AND DEATH 48 hrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Myocardial Infarction
48 hrs.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Port MI → Shock → Acute Renal Failure | | | | 19. DATE OF OPERATION | |
| 20. AUTOPSY? (Yes or No) Yes | | 21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 10/23 1967 to 10/24 1967 , that (2) (we) last saw the deceased alive on 4:20 P.M. 10/24 1967 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Frederick P. Stitik M.D. | | | | 23B. DATE SIGNED
10/24/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Frederick P. Stitik | | | | 23D. ADDRESS
University Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/28/67 | | 24C. NAME OF CEMETERY or CREMATORY
Lorraine Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
10/27/1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
H.H. Witzke & Sons 4101 Edmondson Ave. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------|--|---|--|-------------------------------|
| 67 10237 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10237 | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Lillie M. Campbell | | 10/25-67 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
Maryland | | B. COUNTY
Balto. | |
| General German Aged Peoples Home
22 S. Athol Ave. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | 22 S. Athol Ave | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | If Under 1 Yr.
Months Days |
| female | Cauc. | Widowed | Feb. 25, 1881 | 86 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| | | | Maryland | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| John V. Lotz | | | Elizabeth | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | 212-09-4209 | | German Aged Home 22 S. Athol Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Cardio Respiratory failure | |
| ANTECEDENT CAUSES | | (B) DUE TO | | Cerebral Vascular Accident | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | Generalized Arteriosclerosis | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 19 67 to 25 Oct. 19 67, that (I) (we) last saw the deceased alive on 25 Oct. 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| William J. Bryson | | | | 26 Oct. 67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Dr. William J. Bryson | | 4605 Edmondson Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 10/27/67 | | Loudon Park Cemetery | |
| | | | | Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| OCT 27 1967 | | Robert E. Finkbeiner | | H. H. Witzke & Sons 4101 Edmondson Ave. | |



N-425

67 10238 BALTIMORE CITY HEALTH DEPARTMENT

67 10238

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

CATHERINE

F.

NELSON

2. DATE AND HOUR PRONOUNCED DEAD

October 25, 1967

12:12 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Middle River (20)

D. STREET ADDRESS (If rural, give location)

11 Compression Court

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Oct. 21, 1908

9. AGE (In years last birthday)

59

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Albany, N. Y.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Andrew Cairns

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217 30 4752

17. INFORMANT

ADDRESS

Mary Ann Schepers 25 Left Wing Dr. Balto 20

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Hypertensive and Arteriosclerotic
~~Myocardial~~ Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/25/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

10/30/67

23C. NAME of CEMETERY or CREMATORY

Arlington National Cemetery Arlington, Va.

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

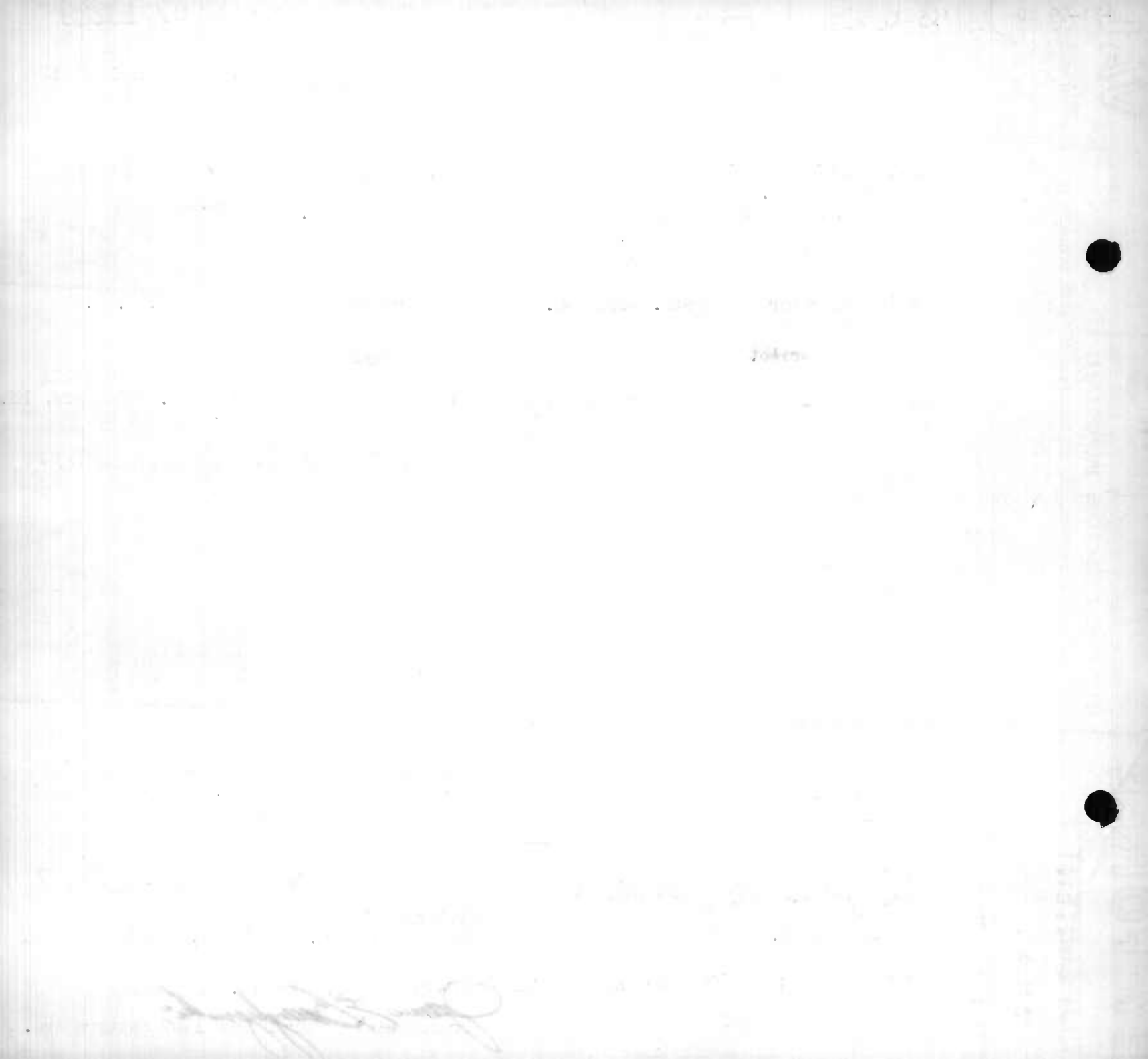
Bruzdzinski Funeral Home 1407 Eastern Ave.

[Handwritten signature]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|--|------------------------------------|--|--|--|--|
| BIRTH NO. <u>W-623</u> | | 67 10239 | | BALTIMORE CITY HEALTH DEPT. | | Registered No. <u>67 10239</u> | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>HARRY C. WRIGHT</u> | | 2. DATE AND HOUR OF DEATH
<u>10-25-67</u> <u>4:00 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Baltimore City Hospitals</u>
<u>4940 Eastern Ave.</u>
<u>Baltimore, Maryland # 21224</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Essex (21)</u>
D. STREET ADDRESS (If rural, give location)
<u>308 Homburg Ave.</u> # <u>21224</u> <u>005</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>9/20/10</u> | 9. AGE (In years last birthday)
<u>57</u> | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Machine Operator</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Beth. Steel Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Harry Wright</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Alta Mayo</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>217 10 1369</u> | | 17. INFORMANT
<u>BCH: Records 4940 Eastern Ave. Baltimore, Md.</u> ADDRESS # <u>21224</u> | | | |
| 18. <u>63X</u> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>Carcinoma of the Lung</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) <u>Carcinoma of the Lung</u>
DUE TO
(B) _____
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>unknown</u> | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (A) (this hospital) attended the deceased from <u>10/15</u> <u>1967</u> to <u>10/25</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Raymond J. LaSure</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
<u>10-25-67</u> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Raymond J. LaSure</u> M.D. | | | | 23D. ADDRESS
<u>Baltimore City Hospitals</u>
<u>4940 Eastern Ave. Baltimore, Maryland #21224</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>10/28/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Gardens of Faith Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore Co. Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 27 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Tarkenton</u> | | 25C. FUNERAL DIRECTOR
<u>Bruzdzinski Funeral Home</u> | | ADDRESS
<u>1407 Eastern Ave.</u> | |



| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
|---|---------|---|---|---|--|
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| RICHARD H HICKS | | October 19, 1967 11:15 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
Maryland | | | |
| 44 Union Memorial Hospital | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
2792 Tivoly Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Male | Negro | married | June 21-1932 | 35 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| | | Saturday | Virginia, U.S.A. | | |
| 13. FATHER'S NAME | | 14. MOTHER'S NAME | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| Thomas Hicks | | Emma Walker | | Yes | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH | |
| 216281573 | | Family | | Left subdural hematoma | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | Unknown | | Unknown | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| Unknown | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | Probably fell | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| Charles S. Springate, M.D. | | | | October 20, 1967 | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | |
| Burial | | 10/24/67 | | Baltimore National Cemetery, Baltimore, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | |
| OCT 27 1967 | | Robert E. Fawcett, M.D. | | Robert Williams, 1701 N Bond St | |

General report of the
1871-72 season

FUNERAL DIRECTOR: IMPORTANT

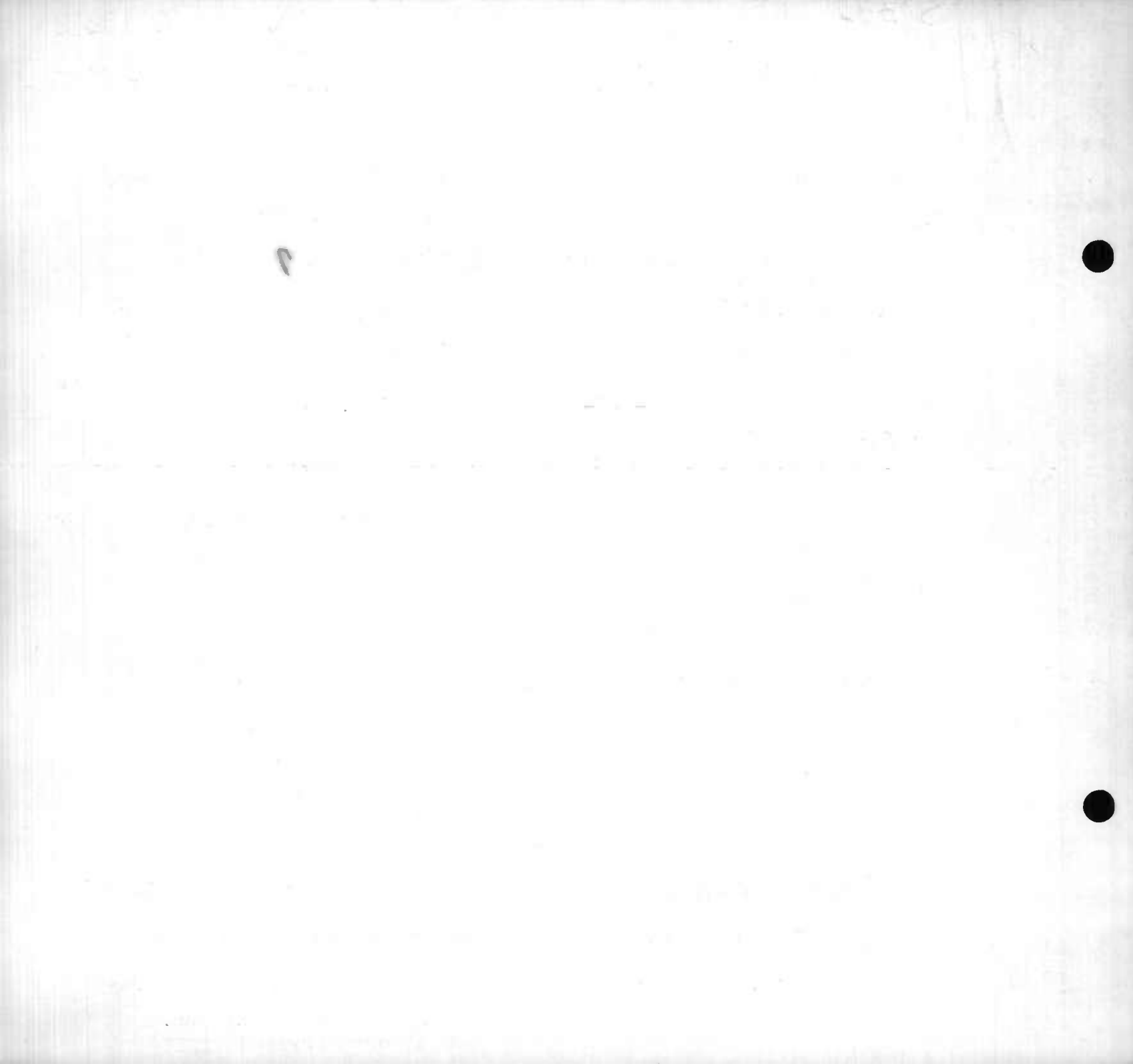
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10241 | |
|---|------------------|--|---------------------------------------|--|---|
| BIRTH NO. 7-230 | | 67 10241 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) EDMUND GEORGE FOSTER | | 2. DATE AND HOUR OF DEATH 10-25-67 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Md. B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. | |
| 48 Maryland General Hospital | | D. STREET ADDRESS (If rural, give location) 2819 Overland Avenue | | 27-02 | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH Mar. 16, 1897 | 9. AGE (In years last birthday) 70.3 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hughes Furniture Sales | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Md. Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME William Foster 214-03-9996A | | 14. MOTHER'S MAIDEN NAME Augusta Milkr | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/26/18 1/16/19 | | 16. SOCIAL SECURITY NO. 415-54-4359 | | 17. INFORMANT Mrs Stella M. Foster Address Chart 2819 Overland Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.1 I | | (A) DUE TO Coronary Thrombosis | | 16 days | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 10-9 1967 to 10-25 1967 , that (H) (we) last saw the deceased alive on 10-25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE L. Kenge Owens | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 10-25-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS 6 E. Read St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Oct. 27, 1967 | | 24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. Gardens Cockeysville Md. | |
| 24D. LOCATION (City, town, or county) (State) | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 27 1967 | | 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. ADDRESS BALTIMORE, MARYLAND 21213 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------|--|--------------------------|---|--|
| BIRTH NO. 67 10242 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10242 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ANDREW J. STETSER) STETSER, ANDREW | | 2. DATE AND HOUR OF DEATH 10/26/67 4:35 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE NEW JERSEY
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) WOODS TO WN V-27
D. STREET ADDRESS (If rural, give location) 230 HOWARD AVE. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10/3/10 | 9. AGE (In years lost birthday) 57 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR DUPONT | | 10B. KIND OF BUSINESS OR INDUSTRY DUPONT | | 11. BIRTHPLACE (State or foreign country) New Jersey | |
| 13. FATHER'S NAME John Stetser | | 14. MOTHER'S MAIDEN NAME Frances Van Roma | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 146 - 05-1489 | | 17. INFORMANT ADDRESS 230 Howard Ave Mrs Hazel R. Stetser Woodstown | |
| 18. I 181.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) CARDIAC ARREST DUE TO (B) METASTATIC CARCINOMA OF BLADDER 2 yrs DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION COLOSTOMY | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BOWEL OBSTRUCTION | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO | |
| 21D. TIME OF INJURY (APPROX.) NO - | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> NO Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? NO | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/5 19 67 to 10/26 19 67, that (I) (we) last saw the deceased alive on 10/26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Brent L. Horsley | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 10/26/67 | |
| 23C. PHYSICIAN'S NAME (Type) BRENT L. HORSLEY | | 23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10/28/67 | | 24C. NAME OF CEMETERY OR CREMATORY Lawnside | |
| | | | | 24D. LOCATION (City, town, or county) (State) Woodstown New Jersey | |
| 25A. DATE RECD BY HEALTH DEPT. OCT 27 1967 | | 25B. NAME OF REGISTRAR Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR Henry Sander & Sons Inc. ADDRESS Baltimore Maryland 21213 | |



11-655 67 10243

BALTIMORE CITY HEALTH DEPARTMENT

67 10243

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ELIZABETH

KARL

NORMAN

2. DATE AND HOUR PRONOUNCED DEAD

October 24, 1967

1:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1905 E. Pratt Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

JUNE 29 1896

9. AGE (In years
last birthday)

71

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PACKING HOUSE

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JNK SQUIRES

14. MOTHER'S MAIDEN NAME

JNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

220-01-3266A

17. INFORMANT

ADDRESS

JOSEPH J NORMAN 1905 E PRATT ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/24/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

OCT 27 1967

23C. NAME of CEMETERY or CREMATORY

MT CARMEL CEMETERY

23D. LOCATION

(City, town, or county)

(State)

O'DONNELL ST

MD.

24A. DATE REC'D BY HEALTH DEPT.

OCT 27 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

DIPPEL BROS INC 1800 E LOMBARD ST

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10244 | |
| BIRTH NO. 67 10244 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) HELEN MISIUK | |
| 2. DATE AND HOUR OF DEATH
OCTOBER 25 1967 12:30 P.M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE | | 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2413 FLEETWOOD | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | D. STREET ADDRESS (If rural, give location)
2413 FLEETWOOD AVE | |
| 6. SEX
FEMALE | 7. RACE
CAUCASIAN | 8. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 9. DATE OF BIRTH
JUNE 1, 1879 |
| 10. AGE (In years last birthday)
88 | 11. BIRTHPLACE (State of foreign country)
POLAND | 12. CITIZEN OF WHAT COUNTRY?
1ST PAPERS | 13. FATHER'S NAME
ANTHONY VINCENT |
| 14. MOTHER'S MAIDEN NAME
UNKNOWN | 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
NO | 16. SOCIAL SECURITY NO.
NONE | 17. INFORMANT
DOROTHY HERRING |
| ADDRESS
2413 FLEETWOOD AVE. | | 18. CAUSE OF DEATH
ASCVD | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ASCVD | | 20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 21A. DATE OF OPERATION
NO | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 21C. AUTOPSY? (Yes or No)
NO | 21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 22A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 22C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) |
| 22E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 22F. HOW DID INJURY OCCUR? | 22. I certify that (1) (this hospital) attended the deceased from 1966 to 1967 , that (1) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE
George H. Beck | 23B. DATE SIGNED
10/25/67 | 23C. PHYSICIAN'S NAME (Type)
GEORGE H. BECK | 23D. ADDRESS
6012 HARFORD RD., Balt., Md. |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | 24B. DATE
OCT 28, 67 | 24C. NAME OF CEMETERY or CREMATORY
HOLY TRINITY CEM. | 24D. LOCATION (City, town, or county) (State)
ELK RIDGE MD. |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | 25B. NAME OF REGISTRAR
Robert E. Jankowski | 25C. FUNERAL DIRECTOR
DIPPEL BRO'S INC | 25D. ADDRESS
7110 BELAIR RD. |

~~RECEIVED~~
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

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FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

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U. S. DEPARTMENT OF JUSTICE

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 10245</u> | |
|--|-------------------------|---|--------------------------------------|--|---|
| 67 10245 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MAGGIE REAVES | |
| 2. DATE AND HOUR OF DEATH
OCT. 25, 1967 10³⁵ A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 LINCOLN MEMORIAL NURSING HOME | | A. STATE
MARYLAND | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
204 N. AMITY STREET | | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
2/12/1889 | 9. AGE (In years last birthday)
78 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
HENRY STOKES | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
212-10-1024 | | 17. INFORMANT
Records | |
| 18. 434.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
CONGESTIVE HEART FAILURE | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-7 19 64 to 10-25 19 67 , that (I) (we) last saw the deceased alive on 10-25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Henri Deunarine M.D.</i> | | | | 23B. DATE SIGNED
10/25/67 | |
| 23C. PHYSICIAN'S NAME (Type)
HENRI DEUNARINE | | | | 23D. ADDRESS
3519 KENNISON AVE BALT | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/28/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt Auburn | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
Charles A Rice | |
| ADDRESS
6618 Bare | | | | | |

Lincoln Memorial Drive & 14th St
204 N. AMITY STREET
2/12/1887 48

Virginia
UNKNOWN
HENRY STOKES
212-10-1024

CONGESTIVE HEART FAILURE

10 - 22 - 21
2 - 1
10 - 22 - 21

10/22/21
224 Franklin St, N.Y.C.
The Stokes
10/22/21

1
P-516

67 10246 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10246

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOYCE

PUMPHREY

2. DATE AND HOUR PRONOUNCED DEAD

October 24, 1967

1:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1514 McCulloh Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

S

8. DATE OF BIRTH

10/2/53

9. AGE (In years
last birthday)

14

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

School

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George M. Pumphrey Jr.

14. MOTHER'S MAIDEN NAME

Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Virginia Pumphrey 1514 McCulloh St

18.

E981X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wound of Head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home of Friend

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1613 Division St.

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
10/24/67 1:10 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot by male while
playing Russian Roulette.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/24/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/28/67

23C. NAME of CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION (City, town, or county)

Baltimore, Md

24A. DATE REC'D BY HEALTH DEPT.

OCT 27 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Charles A. Rice 661 W Barre St

ADDRESS

WATKINS PAPER

NO. 10

1891

Wm. H. Watkins

10/1/91

Watkins Paper Co. 12 1/2 in. wide

Watkins Paper Co. 12 1/2 in. wide

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--------------|--|---|---|---|
| 67 10247 | | 67 10247 | | 67 10247 | |
| <div> <div>1. NAME OF DECEASED
(Type or Print)</div> <div>GRACEN, MATTHEWS</div> </div> <div> <div>2. DATE AND HOUR OF DEATH</div> <div>10/25/67 9:45 AM</div> </div> | | | | | |
| <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>48 Md. GENERAL HOSPITAL</div> </div> | | | <div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div> <div>A. STATE</div> <div>MD</div> </div> <div> <div>C. CITY OR TOWN</div> <div>BALTO</div> </div> <div> <div>D. STREET ADDRESS</div> <div>112 W. UNIVERSITY PARKWAY</div> </div> | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
1/11/93 | 9. AGE (In years last birthday)
74 | <div>If Under 1 Yr. Months: Days: Hours: Min.</div> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CHARLES W. KAGLE | | | 14. MOTHER'S MAIDEN NAME
KATE DISTELLBART | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
213-10-8924 | | 17. INFORMATION (Name, address, relationship)
CHARLES J. NAGLE
604 W. 38th STR
(Sister in Law) | |
| <div>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</div> <div>CAUSE OF DEATH</div> <div>(A) DUE TO Lymphoblastic lymphoma</div> <div>(B) DUE TO</div> <div>(C) DUE TO</div> | | | <div>INTERVAL BETWEEN ONSET AND DEATH</div> | | |
| <div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| <div>22. I certify that (I) (this hospital) attended the deceased from 10/1 1967 to 10/25 1967.</div> <div>that (I) (we) lost saw the deceased alive on 10/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div> | | | | | |
| 23A. SIGNATURE
Q. N. Maunick | | | | 23B. DATE SIGNED
10/25/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Q. N. Maunick | | | | 23D. ADDRESS
M.O. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-27-67 | | 24C. NAME OF CEMETERY or CREMATORY
Woodlawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MD | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | |
| 25C. FUNERAL DIRECTOR
Ellsworth ARMARIST | | 25D. ADDRESS | | 25E. ADDRESS | |



S-300

67 10248

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 10248

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

FORREST

B.

SCOTT

2. DATE AND HOUR PRONOUNCED DEAD

October 25, 1967

6:50 A.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

560 McMechen St.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

560 McMechen Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

7/9/16

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Henry C Scott

14. MOTHER'S MAIDEN NAME

Della E Hawkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
220-03-9249

17. INFORMANT

ADDRESS

Mrs Hazel S Ford, 1712 Madison Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/25/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/30/67

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

OCT 27 1967

Robert E. Farber, M.D.

A Halstead 1206 W North Ave

VALLEY FOLIO

| | | | |
|---|------------------------------|---|---|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print)
JERRY J. | | 2. DATE AND HOUR PRONOUNCED DEAD
October 24, 1967 1:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
38 University Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Washington Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Hagerstown
D. STREET ADDRESS (If rural, give location)
329 S. MONT VALLA Mount Valley St. | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
April 15, 1952 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
STUDENT | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
15 |
| 11. BIRTHPLACE (State or foreign country)
Hagerstown, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph W. McElroy, Sr. | | 14. MOTHER'S MAIDEN NAME
Gloria Shinn | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-54-4278 | |
| 17. INFORMANT
Joseph W. McElroy | | ADDRESS
329 S. MONT VALLA HAGERSTOWN Md. | |
| 18. CAUSE OF DEATH
824.4
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cranio-Cerebral Injury
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Hopewell Rd. - 100 ft. South of Route 144 | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
10/23/67 10:40 P. | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Riding on fender of car - fell off - two cars ran over him | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED
10/24/67 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | 23B. DATE
10/27/67 | 23C. NAME OF CEMETERY or CREMATORY
ROSE HILL CEMETERY | 23D. LOCATION (City, town, or county) (State)
HAGERSTOWN MARYLAND |
| 24A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | 24B. NAME OF REGISTRAR
Robert E. Farley, M.D. | |
| 24C. FUNERAL DIRECTOR
CHARLES M. ROUZER, | | ADDRESS
HAGERSTOWN, MARYLAND. | |

WONT VALLEY

ST. GEORGE

200-24-412-1000

110

200-24-412-1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

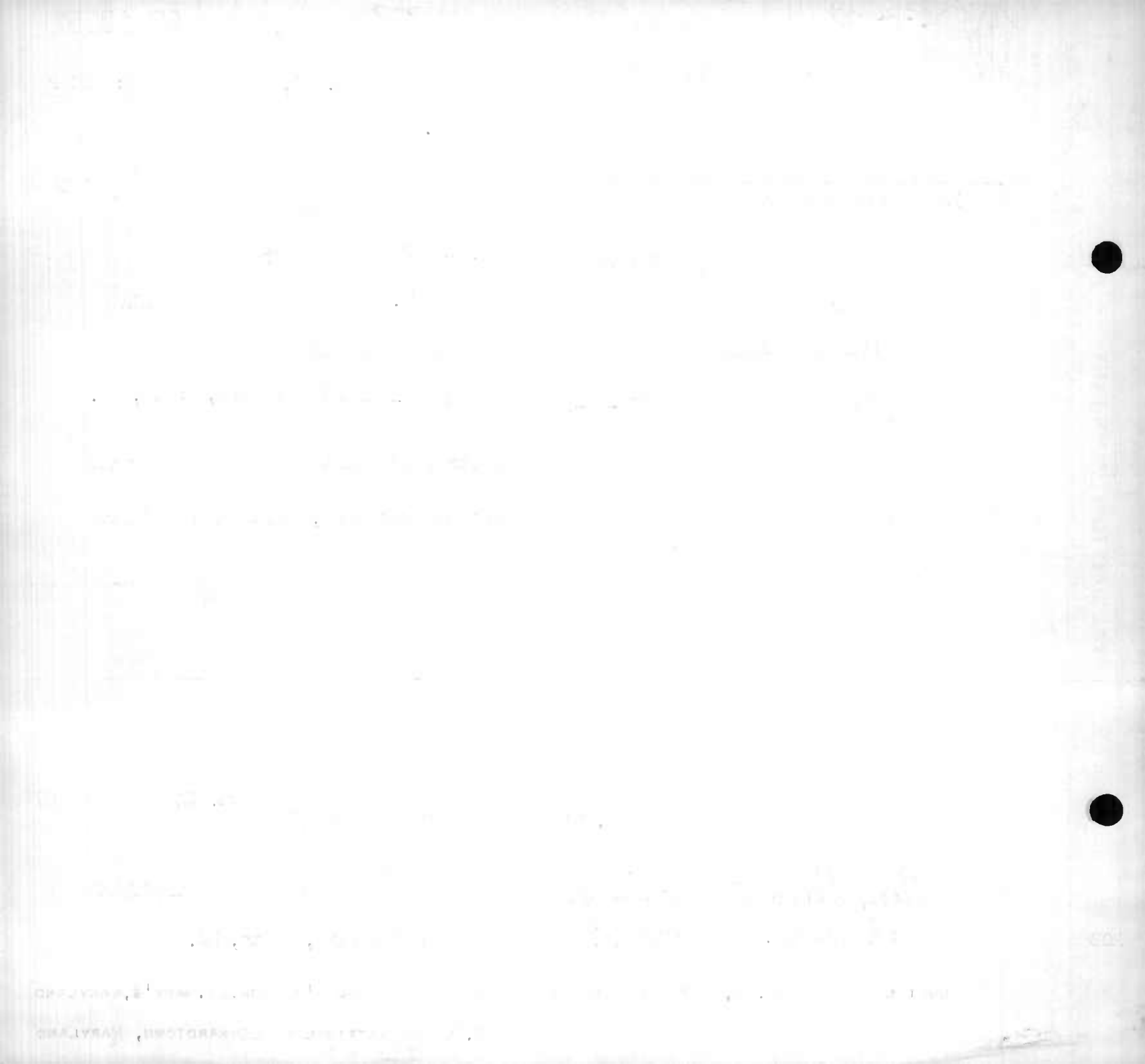
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--------------|---|--|---|--|---|-----------------------|--|--|
| BIRTH NO.
67 10250 | | CERTIFICATE OF DEATH | | | | Registered No.
67 10250 | | | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print)
June Jo-Ann Preston | | | | | 2. DATE AND HOUR OF DEATH
Oct. 25 1967 3 : 15 A M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
3100 Wyman Park Drive | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md.
B. COUNTY Allegany
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Barton rural
D. STREET ADDRESS (If rural, give location)
Butcher Run | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
4/30/38 | 9. AGE (In years last birthday)
29 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Pa. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Donald Allan | | | 14. MOTHER'S MAIDEN NAME
Charlotte Muir | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-36-7769 | | 17. INFORMANT
Records- US PHS Hospital, Balto, Md. | | | ADDRESS | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Pulmonary edema
(A) DUE TO
Acute leukemia
(B) DUE TO
(C) DUE TO
INTERVAL BETWEEN ONSET AND DEATH
Hours
Months | | | | | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 1 19 67 to Oct. 25 19 67, that (I) (we) last saw the deceased alive on Oct. 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
James M. Weaver
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED
10/25/67 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
James M. Weaver, Medical Director M.D. | | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/28/67 | | 24C. NAME of CEMETERY or CREMATORY
Laurel Hill | | 24D. LOCATION (City, town, or county) (State)
Moscow Mills Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Talley, M.D. | | 25C. FUNERAL DIRECTOR
E. J. Boal | | ADDRESS
Westernport, Md. | | | |

20483

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|------------------------------------|---|---|
| BIRTH NO. 67 10251 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10251 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) JOSEPH ARCHIE RUSSELL | | 2. DATE AND HOUR OF DEATH
Oct. 24, 1967 2: 10 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Leonardtwn | |
| FULL NAME OF HOSPITAL OR INSTITUTION
US Public Health Service Hospital
3100 Wyman Park Drive | | D. STREET ADDRESS (If rural, give location)
Route 1 Box 65 | | E. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
3/19/24 | 9. AGE (In years lost birthday)
43 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Md. | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Spaulding Russell | | 14. MOTHER'S MAIDEN NAME
Bertie Redmond | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
220-50-5173 | | 17. INFORMANT
Records- US PHS Hospital, Balto, Md. | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Bilateral pneumonia | | CAUSE OF DEATH
(A) DUE TO
Bilateral pneumonia | | INTERVAL BETWEEN ONSET AND DEATH
one week | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
Malignant melanoma, metastatic | | 2 yrs | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from May 22 19 67 to Oct. 24 19 67 , that (1) (we) last saw the deceased alive on Oct. 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Cary Presant SA Surg. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/24/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Cary Presant, SA Surgeon (R) | | M.D. 23D. ADDRESS
US PHS Hospital, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
Oct. 27, 1967 | | 24C. NAME of CEMETERY or CREMATORY
OUR LADY'S CHAPEL | |
| 24D. LOCATION (City, town, or county) (State)
MEDLEY'S NECK, ST. MARY'S, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley | |
| 25C. FUNERAL DIRECTOR
W. CLARKE MATTINGLEY | | ADDRESS
LEONARDTOWN, MARYLAND | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. _____ | |
|---|-------------------------|--|---|--|---|
| BIRTH NO. B-550 | | 67 10252 | | 67 10252 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Viola Bowman | | | 2. DATE AND HOUR OF DEATH
10/23/67 4²⁵ A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
33 Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND B. COUNTY ST. MARY'S
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
LEXINGTON PARK RT 235 68-00
D. STREET ADDRESS (If rural, give location) | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
8-19-26 | 9. AGE (In years last birthday)
41 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | | 11. BIRTHPLACE (State or foreign country)
Mo. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
WILLIAM THOMAS BISCOE | | | 14. MOTHER'S MAIDEN NAME
MARGARET BUTLER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
CARROLL E. BOWMAN ADDRESS
LEXINGTON PARK, MD. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
18/10 I
EARLY ARREST
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
metastatic carcinoma from the bladder | | | INTERVAL BETWEEN ONSET AND DEATH
1 yr | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
malnutrition | | | | | |
| 19A. DATE OF OPERATION
11/22/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Bladder Ca | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/7 1967 to 10/23 1967 , that (I) (we) lost saw the deceased alive on 10/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
W.C. Robertson, Jr. | | | 23B. DATE SIGNED
10/23/67 | | |
| 23C. PHYSICIAN'S NAME (Type)
W.C. Robertson, Jr. | | | 23D. ADDRESS
J H H Balt. Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
OCT. 28, 1967 | | 24C. NAME OF CEMETERY or CREMATORY
HOLY FACE CEMETERY | |
| 24D. LOCATION (City, town, or county) (State)
GREAT MILLS, ST. MARY'S, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 27 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, Jr. | | 25C. FUNERAL DIRECTOR ADDRESS
W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | | |

John Hopkins Hospital

3-12-1918

Robertson
for the bladder
resectomy
case

Master
bladder

10/15

W.C. Robertson
Chc. Robertson

2 H H 1300 M

10/23/18

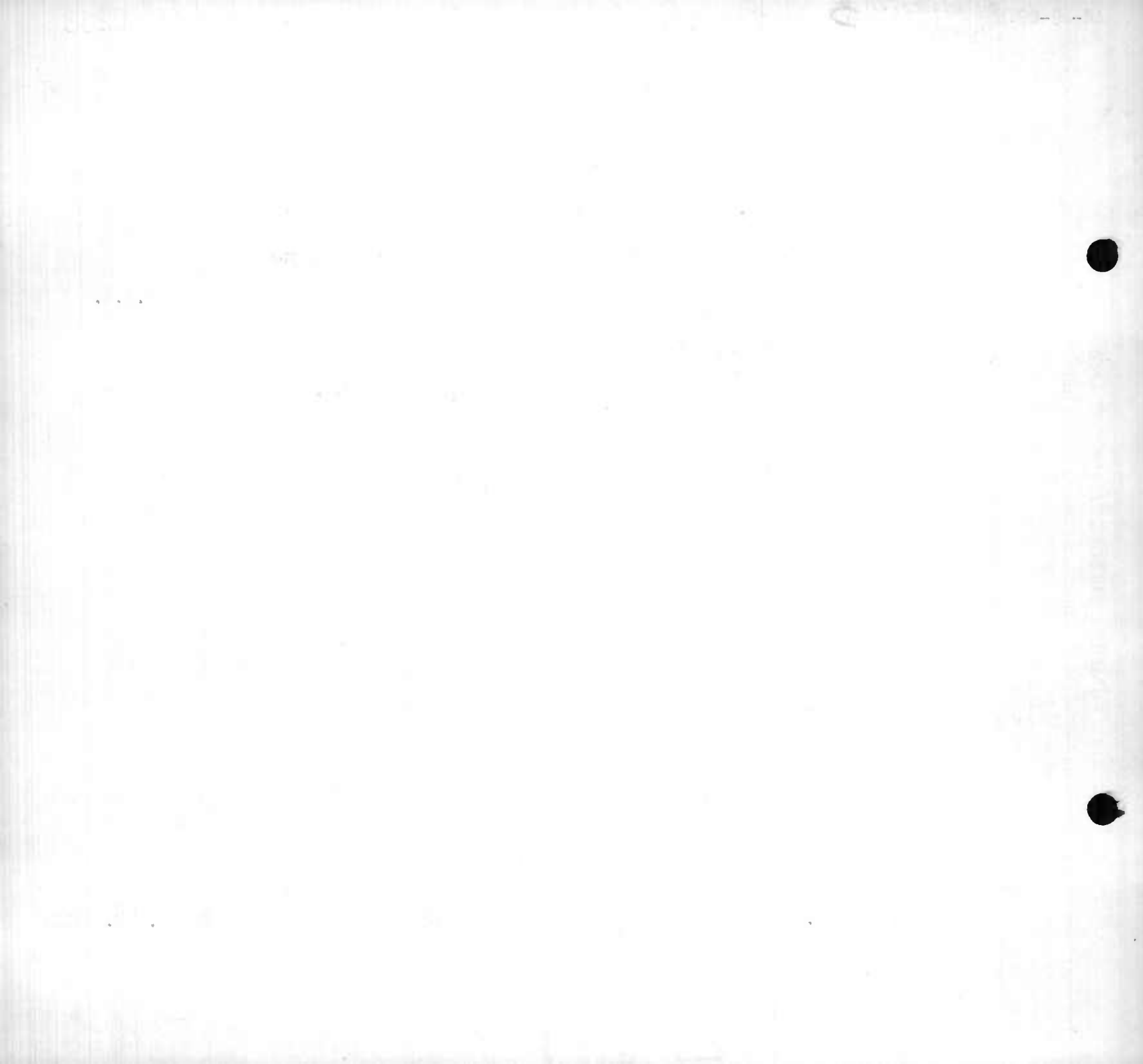
8/1

10/13

10/13

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|---|--|---|---------------------------|
| 67 10253 | | 67 10253 | | 67 10253 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | SAMUEL CLARK | | OCT. 26, 1967 2 ³⁰ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | MARYLAND | | BALTIMORE Co | |
| BALTIMORE CITY HOSPITALS | | C. CITY OR TOWN | | (If outside city limits, write RURAL and give township) | |
| 4940 EASTERN AVENUE | | Baltimore | | 53-00 | |
| BALTIMORE, MARYLAND 21224 | | D. STREET ADDRESS | | (If rural, give location) | |
| | | 207 WALNUT AVENUE | | 21221 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED | 8. DATE OF BIRTH | 9. AGE (In years) | 10. Under 1 Yr. |
| Male | NEGRO | WIDOWED, DIVORCED (specify) | 10-15-1898 | 69 | Months: Days: Hours: Min. |
| | Negro | MARRIED | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Laborer | | Sparrows Point | | SOUTH CAROLINE, Chester | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| U.S.A. | | FLETCHER Clark | | SISLEY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes | | 215-07-8367 | | BCH: RECORDS 4940 EASTERN AVENUE 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | 10 months | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Atherosclerosis, generalized | | > 20 years | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 0 | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/3 19 67 to 10/26 19 67, that (I) (we) last saw the deceased alive on 10/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. | | 23B. DATE SIGNED | |
| Benjamin Lechner, M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | Oct. 26, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | BALTO. MD. 21224 | |
| DR. BENJAMIN LECHNER | | 4940 EASTERN AVENUE | | | |
| BENJAMIN LECHNER | | Balt City Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION | (City, town, or county) (State) | |
| Burial | 10-31-67 | Balto. Nat'l Cem. | Balto. | Md. | |
| 25A. DATE RECD. BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| OCT 27 1967 | Robert E. Taylor, M.D. | Morton E. Dyett F.H. | | 1701 Laurens | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10254 | |
|---|-----------|--|--|--|---|
| BIRTH NO. 67 10254 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. MAE RAYMAN | | 1. NAME OF DECEASED (Type or Print) Rayman - Mae | | 2. DATE AND HOUR OF DEATH 6:45 PM 10-26-67 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital
48 | | | A. STATE B. COUNTY
Baltimore | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 7-02 | | |
| | | | D. STREET ADDRESS (If rural, give location)
809 Rose St. Baltimore Md. | | |
| 5. SEX Female | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 4-13-21 | 9. AGE (In years last birthday) 46 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Baltimore | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Henry Okol | | | 14. MOTHER'S MAIDEN NAME Anna Kane | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT prev. adm. ADDRESS | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH CARCINOMATOSIS
metastatic carcinoma of the lung
MALIGNANT MELANOMA
metastatic carcinoma of the lung
DUE TO OF (C) EYE, RESECTED | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 21 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-24-67 to 10-26-67, that (I) (we) last saw the deceased alive on 10-26-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE cyrus makowi | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 10-26-67 |
| 23C. PHYSICIAN'S NAME (Type) cyrus makowi | | | 23D. ADDRESS Maryland Gen. Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10/30/67 | | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn | |
| 24D. LOCATION Baltimore | | 24E. LOCATION (City, town or county) | | 24F. LOCATION (State) | |
| 25A. DATE RECEIVED BY HEALTH DEPT. 10/30/67 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Philip Hawley | |
| 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS | |

24 12 1914

W. H. H. H.

W. H. H. H.

W. H. H. H.

W. H. H. H.

200

W. H. H. H.

W. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

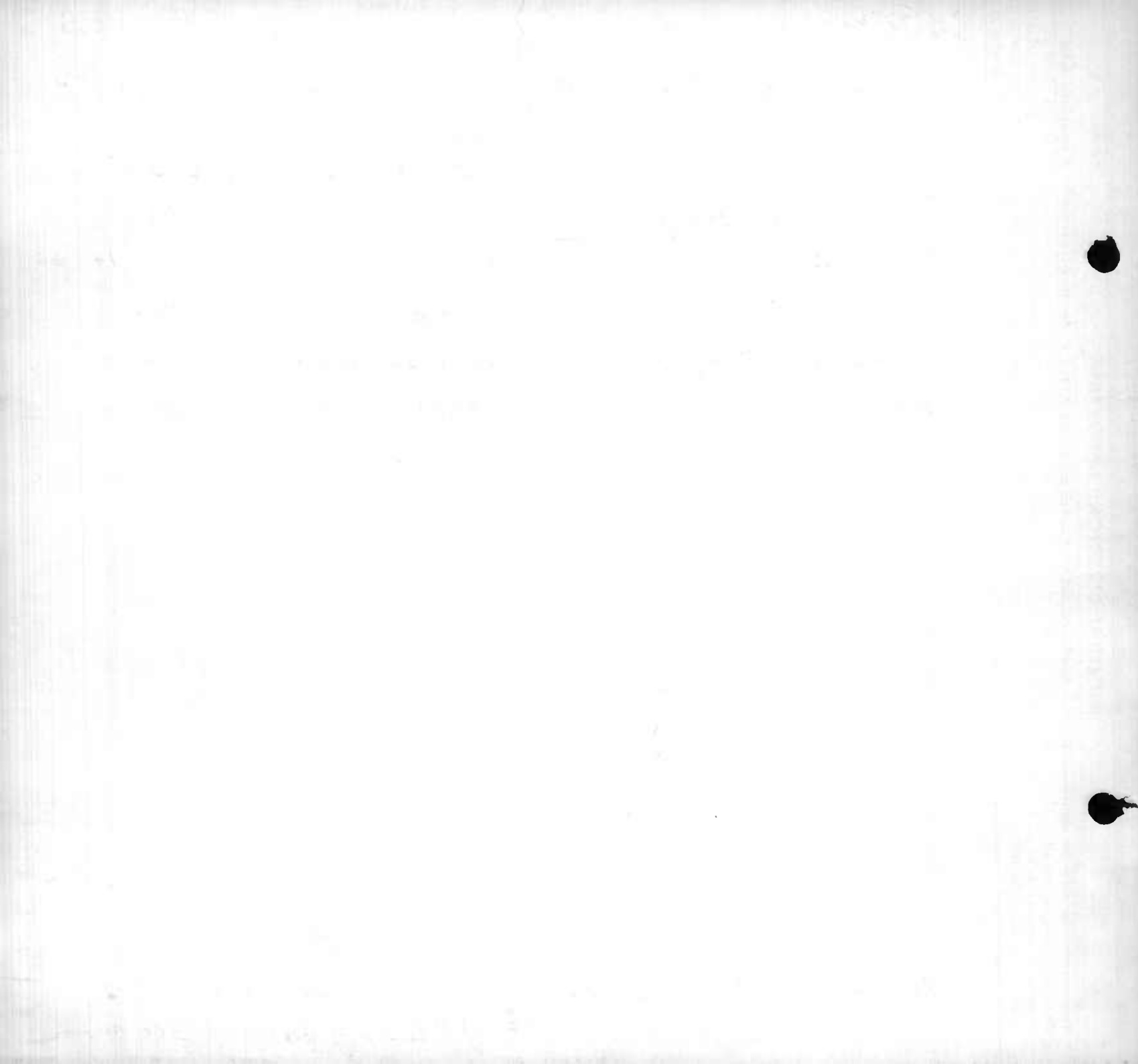
| | | | | | | | | | |
|--|---------|--|------------------|---|----------------------------|--|--|----------|--|
| C-523
BIRTH NO. | | 67 10255 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. X | | 67 10255 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | | | |
| | | Sister Mary Constance | | October 26, 1967 | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. CITY | | 56th and City Line Bon Secours/Phila, Pa. | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Phila., Pa. | | | | | |
| Bon Secours Hospital | | D. STREET ADDRESS (If rural, give location) | | | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | | | |
| Female | White | Religious | 2/12/06 | 61 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Religious | | | | Ireland | | U.S.A. | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| Anthony O'Malley | | Bridget Hughes | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| | | Not recorded | | | | | | | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Coronary Infarction | | 2 days | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | Coronary Arteriosclerosis | | 1 Year | | | |
| | | (C) | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| None | | | | No | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | White At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1960 to 10/26 1967, that (I) (we) last saw the deceased alive on 10/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | | 10/26/67 | | | |
| J. Emmett Queen | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | | | | | |
| J. EMMETT QUEEN M.D. | | Bon Secours Hosp. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | Oct. 28/67 | | Cathedral Cemetery | | Baltimore Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| OCT 30 1967 | | R. E. Farley M.D. | | Harley Funeral Home | | 1101 N. Howard St. Baltimore | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------------------|---|--|---|--|--|--|
| BIRTH NO. <u>67-21217</u> | | 67 10256 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>67 10256</u> | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Sayer, Baby Boy</u> | | | | 2. DATE AND HOUR OF DEATH
<u>10-25-67</u> <u>11 30</u> P. M. | | | |
| 3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>md.</u> B. COUNTY <u>Balt. Co.</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>LUTHERAN HOSPITAL</u>
(If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore # 21210 53-00</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>12 STABILIZER DR</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify) | | 8. DATE OF BIRTH
<u>10-25-67</u> | 9. AGE (In years last birthday)
<u>17</u> | If Under 1 Yr. Months: Days: <u>17</u> <u>20</u> | If Under 24 Hrs. Hours: Min. <u>20</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>EARL F. Sayer</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Theresa Marie Cannon</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>EARL F. SAYERS</u> | | ADDRESS
<u>ABOVE</u> | |
| 18. <u>774X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) <u>Prematurity</u>
DUE TO
(B) <u>Cardiorespiratory arrest</u>
DUE TO
(C) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 1/2 hrs.</u> | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> <u>19 67</u> to <u>10/25</u> <u>19 67</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> <u>19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Synobu</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>10/25/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>REMOVAL</u> | | 24B. DATE
<u>10/27/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>TAZEWELL</u> | | 24D. LOCATION (City, town, or county) (State)
<u>TAZEWELL VA.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 30 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fairley</u> | | 25C. FUNERAL DIRECTOR
<u>J. J. Connelly Sons</u> | | ADDRESS
<u>300 more</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|---|--|---|
| BIRTH NO. 67 10257 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10257 | |
| M.E. CASE NO.
1. NAME OF DECEASED (Type or Print) HARRY P. GESSIN | | | 2. DATE AND HOUR OF DEATH
10/24/67 5:10 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
4 UNION MEMORIAL HOSP. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
12-02
D. STREET ADDRESS (If rural, give location) MARYLANDER APTS. 3501 ST. PAUL STREET, APT. 402 #21218 | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
DIVORCED SEPARATED | 8. DATE OF BIRTH
3/23/1902 | 9. AGE (In years lost birthday)
65 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ENGINEER, AEROD. AIR FORCE | | | 11. BIRTHPLACE (State or foreign country)
NEW YORK | | 12. CITIZEN OF WHAT COUNTRY?
U.S. |
| 13. FATHER'S NAME
MORRIS GESSIN | | | 14. MOTHER'S MAIDEN NAME
DINA KESTER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
EMANUEL GESSIN
ADDRESS
3501 ST. Paul Balt. 18, MD. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphensia, etc. It means the disease, injury or complication which caused death.)
420.1 I
Acute Myocardial Infarction | | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
ARTERIO-SCLEROTIC Cardiovascular disease | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 10/16 19 67 to 10/24 19 67 , that (I) (we) last saw the deceased alive on 10/24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
W. H. Oehlert Jr.
23C. PHYSICIAN'S NAME (Type)
WILLIAM H. OEHLERT JR M.D. | | | | 23B. DATE SIGNED
10/24/67 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-27-67 | | 24C. NAME OF CEMETERY or CREMATORY
BETH EL | |
| 24D. LOCATION (City, town, or county) (State)
ALLENTOWN, PENNSYLVANIA | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD | | | |

Harold F. Cannon

10/24/67

200 11

Union Memorial Hosp
M W
Directed
Engineer, New Air Force
Morris Cessna

Placed
Contract
3501 27 Ave
3/23/62 62

New York
Dura Kennel

3501 27 Ave
Bolt 15, 16, 17

Gate Myocardial Infarction

Anterior wall myocardial infarction

no

W. H. DeBellef

10/24/67

10/24/67

10/24/67

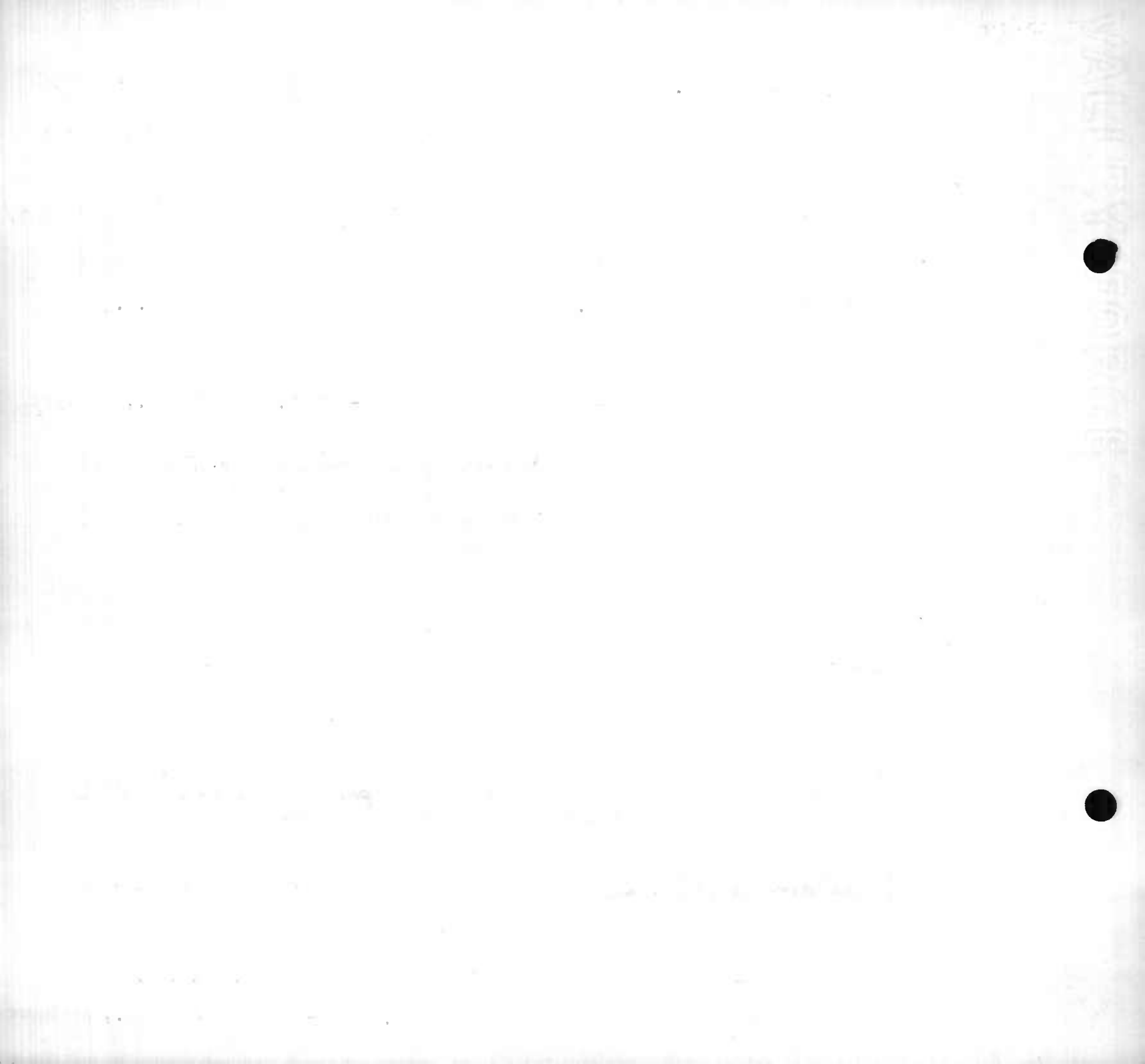
ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-15-01 BY 60322 JAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|---|---|--|
| BIRTH NO. 67 10258 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10258 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED
(Type or Print) <i>William R. Wendel</i> | | |
| 2. DATE AND HOUR OF DEATH
<i>10-24-67 12:17A.M.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>43 South Baltimore General Hosp</i> | | | A. STATE <i>Maryland</i> B. COUNTY <i>49-6052-00</i> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore #21225</i> | | |
| 5. SEX <i>M</i> 6. RACE <i>White</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i> | | | D. STREET ADDRESS (If rural, give location)
<i>248 Edgevale Rd (West)</i> | | |
| 8. DATE OF BIRTH <i>7/31/1905</i> 9. AGE (In years last birthday) <i>62</i> | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Shipfitter</i> | | |
| 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | |
| 13. FATHER'S NAME
<i>George</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Viola Squire</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | 16. SOCIAL SECURITY NO.
<i>218-09-9150</i> | | |
| 17. INFORMANT
<i>Naomi Wendel - 248 W. Edgevale Rd., Baltimore</i> | | | ADDRESS | | |
| 18. <i>420.1 I</i> CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Acute myocardial infarction</i> | | | <i>30 min</i> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>Arteriosclerotic cardiovascular disease</i> | | | <i>?</i> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>none</i> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from <i>10-23-67 11:30 PM</i> to <i>10-24-67 12:17 AM</i> , that the (we) last saw the deceased alive on <i>10-24</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>William J. Marek</i> | | | | 23B. DATE SIGNED
<i>10-24-67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>William J. Marek</i> | | | | 23D. ADDRESS
<i>1213 Light St.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>10-27-1967</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Glen Haven Memorial Park</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Ritchie Hgwy., A.A.Co., Maryland</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 30 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Finkbeiner</i> | | 25C. FUNERAL DIRECTOR
<i>George J. Gonce-4001 Ritchie Hgwy., Baltimore</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

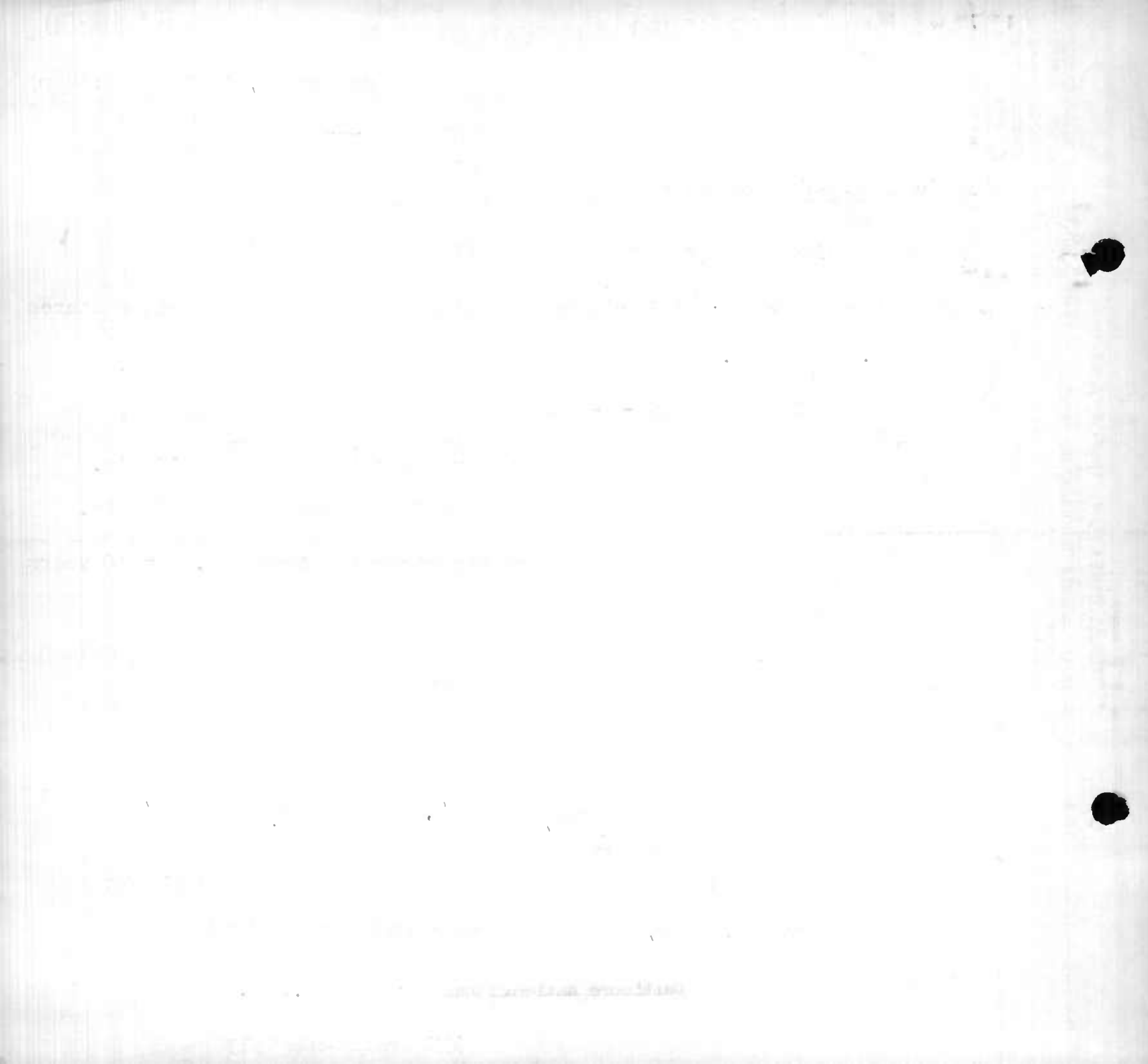
| BIRTH NO. 67 10259 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 10259 | |
|--|-------------------------|---|---|---|--|---|--|----------------------------------|--|
| 1. NAME OF DECEASED
(Type or Print) URBAN, MAX | | | | 2. DATE AND HOUR OF DEATH
OCTOBER 25, 1967 1:06AM M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND B. COUNTY ANNE ARUNDEL | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ST. AGNES HOSPITAL
CATON & WILKENS AVES.
BALTIMORE, MD. 21229 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
PASADENA | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
229 DALE ROAD | | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
01-26-83 | 9. AGE (In years
last birthday)
84 | If Under 1 Yr.
Months Days | | If Under 24 Hrs.
Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sanitary Engineer | | | 10B. KIND OF BUSINESS OR INDUSTRY
Machine Co. | | 11. BIRTHPLACE (State or foreign country)
YUGOSLAVIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | |
| 13. FATHER'S NAME
John Urban | | | | 14. MOTHER'S MAIDEN NAME
----- | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
215 10 9377 | | 17. INFORMANT
CATON & WILKENS AVE | | | |
| 18. 493X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Antecedent Causes
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) Chl. obstr. airway
DUE TO
(B) disease
DUE TO
(C) Pneumonia | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from OCTOBER 12, 1967 to OCTOBER 25, 1967 , that (I) (we) last saw the deceased alive on OCTOBER 25, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
S. Korbuly | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type)
S. KORBULY | | | | 23D. ADDRESS
CATON & WILKENS AVE
ST. AGNES HOSPITAL BALTIMORE, MD. 21229 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-28-1967 | | 24C. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
George J. Gonce | | | ADDRESS
4001 Ritchie Hwy., Baltimore | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. 67 10280 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10280 | |
| 1. NAME OF DECEASED
(Type or Print) HERMAN ALBRECHT | | | 2. DATE AND HOUR OF DEATH
October 26, 1967 7:50 p.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

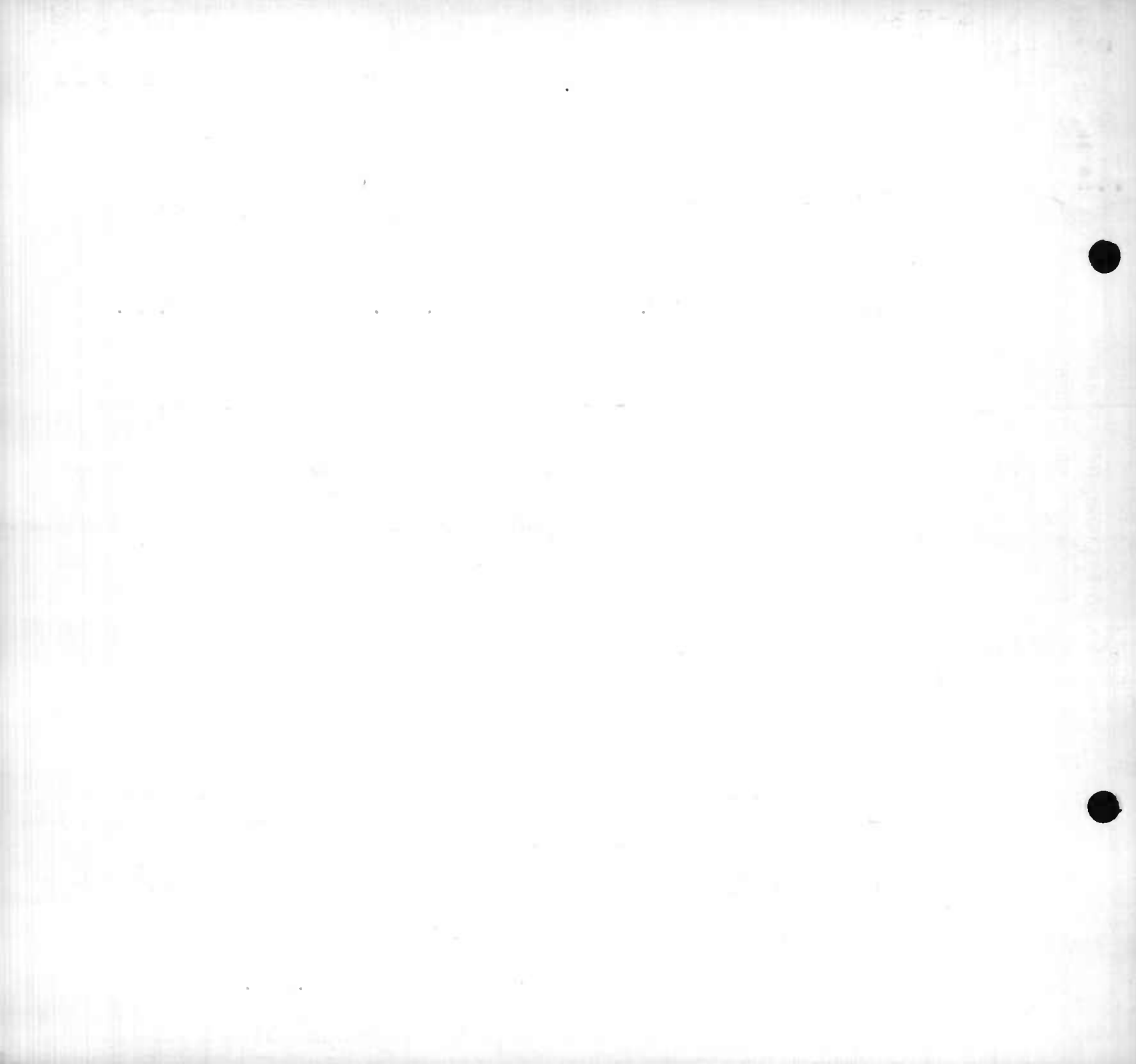
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
5407 Moravia Road #6 | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
Married
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
8/12/26 | 9. AGE (In years last birthday)
41 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Construction worker | | | 10B. KIND OF BUSINESS OR INDUSTRY
Local 193 Boilermaker | | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore | | | 12. CITIZEN OF WHAT COUNTRY?
United States | | |
| 13. FATHER'S NAME
Herman J. Albrecht Sr. | | | 14. MOTHER'S MAIDEN NAME
Margaret Wagner | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes WWII 214-20-5952 | | | 16. SOCIAL SECURITY NO.
214-20-5952 | | |
| 17. INFORMANT
Thelma Albrecht (nee Bell), wife, above | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)
Ventricular fibrillation
INTERVAL BETWEEN ONSET AND DEATH
15 min. | | | CAUSE OF DEATH
(A) DUE TO
Myocardial reinfarction
30 min. | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerotic Heart Dis. x 10 years | | | (B) DUE TO
(C) Arteriosclerotic Heart Dis. x 10 years | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 10/15, 1967 to 10/26, 1967 , that (1) (we) last saw the deceased alive on 10/26, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
David J. Shaw | | | | 23B. DATE SIGNED
10/26/67 | |
| 23C. PHYSICIAN'S NAME (Type)
David J. Shaw, | | | | 23D. ADDRESS
Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/30/67 | | 24C. NAME of CEMETERY or CREMATORY
Meadowridge Mem. Park | |
| 24D. LOCATION
Balto., Md. | | 24E. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | | |
| 25A. NAME OF REGISTRAR
Robert E. Farkas | | 25B. FUNERAL DIRECTOR
Schimunek Funeral Home | | 25C. ADDRESS
3331 Brehms Lane #13 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|------------------|---|-----------------------------|--|--|--|--|
| 1-5-50 | | 67 10261 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10261 | |
| BIRTH NO. 15-50 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) SMITH, Clarence R. | | | | 2. DATE AND HOUR OF DEATH
10/27/67 6:35 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
The Johns Hopkins Hospital | | | | A. STATE Maryland B. COUNTY Baltimore | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 8-01 | | | |
| D. STREET ADDRESS (If rural, give location)
3210 Clifftmont Ave. #13 | | | | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Marries | 8. DATE OF BIRTH
9-17-03 | 9. AGE (In years last birthday)
64 | 10. If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Policeman | | 10B. KIND OF BUSINESS OR INDUSTRY
Balto. City | | 11. BIRTHPLACE (State or foreign country)
Balto., Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
David Smith | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Dimmick | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
216-28-3770 | | 17. INFORMANT ADDRESS
Vella Smith (nee Lilly), wife, above | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (A) DUE TO
Ventricular fibrillation 2 or 3 MI | | INTERVAL BETWEEN ONSET AND DEATH
4 days | |
| | | | | (B) DUE TO
Ischemia | | 4 days | |
| | | | | (C) HASCVD | | 72 yrs. | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 10/23/67 19 to 10/27/67 19, that (I) (we) last saw the deceased alive on 10/27 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Elizabeth H. Jansson | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Elizabeth H. Jansson | | | | 23D. ADDRESS
M.D. Osler Service, Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/30/67 | | 24C. NAME OF CEMETERY or CREMATORY
Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State)
Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
R. E. Farber | | 25C. FUNERAL DIRECTOR
Schimunek Funeral Home
3331 Brehms Lane #13 | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---|---|--|--|---|
| BIRTH NO. 67 10262 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10262 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) ANNA P. NOVAK | | | 2. DATE AND HOUR OF DEATH
10/25/1967 3 30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
00 3700 RAVENWOOD AVE
BALTIMORE, MD 21213 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE _____ B. COUNTY _____

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 26-03

D. STREET ADDRESS (If rural, give location)
3700 RAVENWOOD AVE | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
3-25-95 | 9. AGE (In years lost birthday)
72 | If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
LITHUANIA | |
| 12. CITIZEN OF WHAT COUNTRY?
LITHUANIA | | | 13. FATHER'S NAME
IGNATIUS NOVAK | | |
| 14. MOTHER'S MAIDEN NAME
CATHERINE ? | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | |
| 16. SOCIAL SECURITY NO.
214-01-0201-B | | | 17. INFORMANT ADDRESS
RICHARD NOVAK 3700 RAVENWOOD AVE | | |
| 18. CAUSE OF DEATH
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. 151X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p>(A) Adenocarcinoma of the stomach
DUE TO
2 hepatic metastases

(B) Antecedent
DUE TO

(C) Antecedent
DUE TO

Arteriosclerosis & coronary artery disease</p> </div> <div style="width: 10%;"> <p>INTERVAL BETWEEN ONSET AND DEATH
2 years
4 months

6 years</p> </div> </div> | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 10/22/1960 to October 1967 , that (I) (we) last saw the deceased alive on 10/31/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Paul H. Anniko | | | | 23B. DATE SIGNED
10/26/67 | |
| 23C. PHYSICIAN'S NAME (Type)
PAUL H. ANNICO | | | | 23D. ADDRESS
3800 ERDMAN AVE BALTO. MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-30-67 | | 24C. NAME OF CEMETERY OR CREMATORY
DULANEY VALLEY Mem. | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE MD. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | | |
| 25B. NAME OF REGISTRAR
R. E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
SCHIMMELER FUNERAL HOME INC. 3331 BREHMS LA. BALTO. MD. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Non Med. Released for Medical Examiners Office by: Mr. Frankton Per Mr. Gregory

| | | | | | |
|---|---------------|--|---|--|--|
| BIRTH NO. 67 10263 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10263 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Anna P. Thompson | | | 2. DATE AND HOUR OF DEATH 10.26.67 335 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
The Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3229 Lawnview Ave. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 11-29-97 | 9. AGE (In years lost birthday) 69 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. | | 10B. KIND OF BUSINESS OR INDUSTRY State Health Dept. | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Heter | | | 14. MOTHER'S MAIDEN NAME Annie Ochse | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Marie Kraus, neice, 3204 Clifftmont Avenue | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
CVA: embolic
DUE TO
ASCVD; atrial fibrillation
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
3 days. | | | INTERVAL BETWEEN ONSET AND DEATH 1+ yrs. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 10/30/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10.23.1967 to 10.26.1967, that (I) (we) last saw the deceased alive on 10.25.1967 and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Christopher B. Merritt M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type) Christopher B. Merritt | | | 23D. ADDRESS John's Hopkins Hospital, Balto, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10/30/67 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION Arbutis, Md. | | 24E. DATE REC'D BY HEALTH DEPT. OCT 30 1967 | | 24F. NAME OF REGISTRAR Robert E. Taylor | |
| 24G. FUNERAL DIRECTOR Schimunek Funeral Home | | 24H. ADDRESS 3331 Brehms Lane #13 | | 24I. DATE OF DEATH 10.26.67 | |

7

3.32

10.22.01

7 5

3.40.12

CVA: sample 11

AVCVD: average frequency 1 + 1.2

10.53
10.52

10.53
10.52

10.52
10.51

On 18th June

James Hopkins Workshop, 18th June

Guests: 3, 18th June

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10264

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LOUIS ULLRICH

2. DATE AND HOUR PRONOUNCED DEAD

October 26, 1967

5:35 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1004 Evansway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1004 Evansway

#13

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 25, 1899

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Electrical Dept.

10B. KIND OF BUSINESS OR INDUSTRY

Gas & Electric Co.

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

yes

WWII

16. SOCIAL
SECURITY NO.

212-05-7507

17. INFORMANT

ADDRESS

Elsie Ullrich (nee Graham), wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)X (A) ~~Other~~Chronic obstructive pulmonary
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 27, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/30/67

23C. NAME of CEMETERY or CREMATORY

Holly Hill Mem. Gardens

23D. LOCATION

Maryland

24A. DATE REC'D BY HEALTH DEPT.

OCT 30 1967

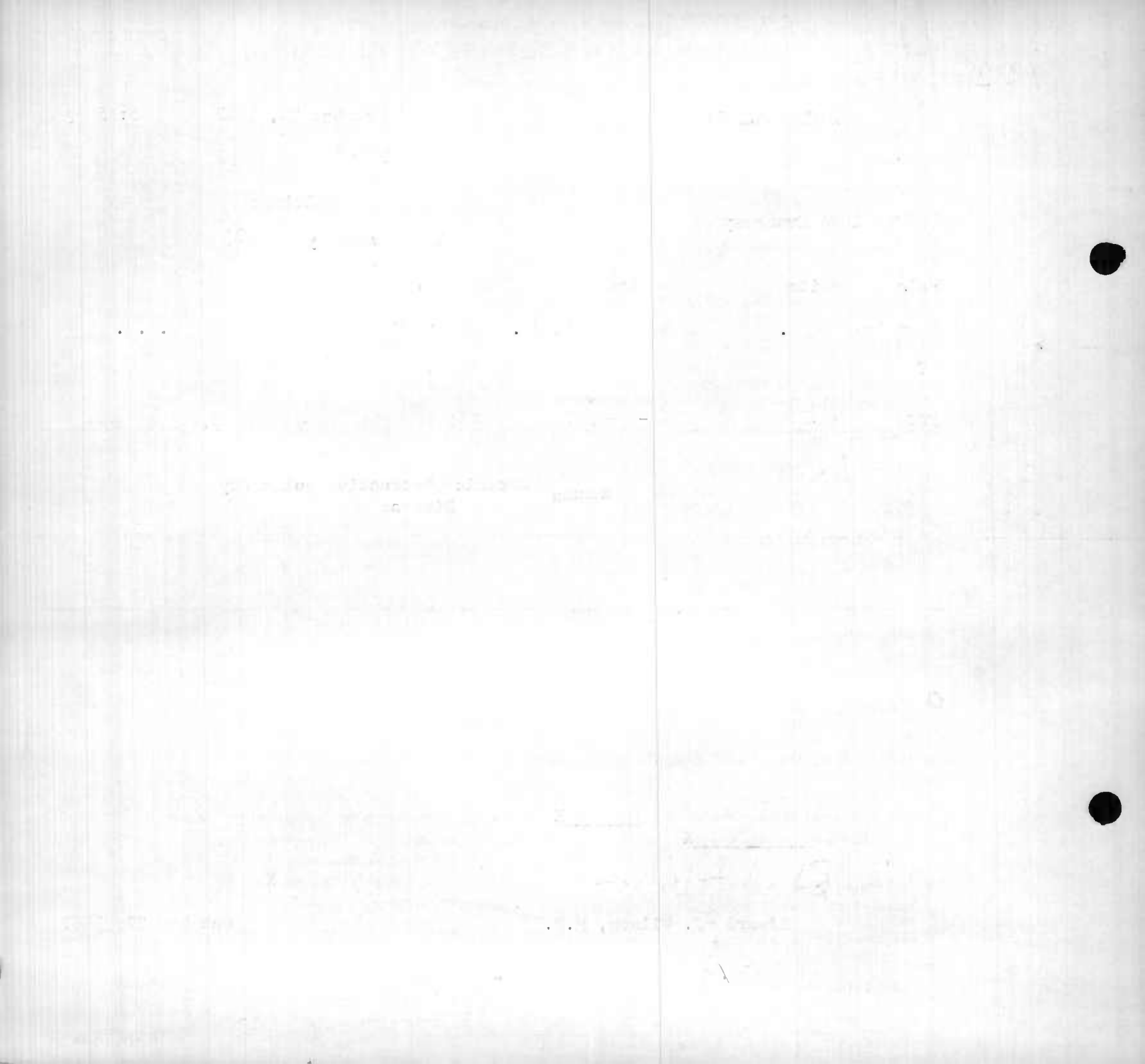
24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Schimunek Funeral Home
3331 Brehms Lane #13

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|---------|--|---|--|------------------------------|
| BIRTH NO. | | 67 10265 | | 67 10265 | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED | | |
| (Type or Print) | | | EMMA E. HULSE | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 2. DATE AND HOUR OF DEATH | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FRANKLIN SQUARE HOSPITAL | | | A. STATE Md. B. COUNTY Baltimore | | |
| 36 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | 3418 Baltimore 25-05 | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 3418 St. Margaret's St. | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| F | WHITE | WIDOW | 2/15/01 | 66 | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| TEACHER | | | | LONG ISLAND N.Y. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| LOUIS HOLTJE | | | MARIE REIMENSCHNIEDER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 214-40-4022 | | SUSAN WOCHKE | |
| | | | | ADDRESS | |
| | | | | RECORDS | |
| | | | | 544 Shipley Rd. Linthicum Hgts | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | ACUTE MYOCARDIAL INFARCTION 8 DAYS | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) DUE TO | | |
| ANTECEDENT CAUSES | | | CORONARY ARTERY DISEASE SEVERAL YEARS | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | |
| | | | (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (netly medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/19/67 to 10/27/67, that (I) (we) last saw the deceased alive on 10/27/67 8:45 p.m. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| P. MACARAE JR. | | | | 10-27-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| P. MACARAE JR. | | FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | Glen Haven | | Glen Burnie Md. | |
| 24B. DATE | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR | |
| 10/31/67 | | McGuffey F.H. | | 237 Patapsco Ave. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| OCT 30 1967 | | McGuffey F.H. | | 237 Patapsco Ave. | |

F. WHITE
TEACHER
ACADEMY

TEACHER

W.C.

TEACHER

TEACHER

TEACHER

TEACHER

TEACHER

FUNERAL DIRECTOR: IMPORTANT

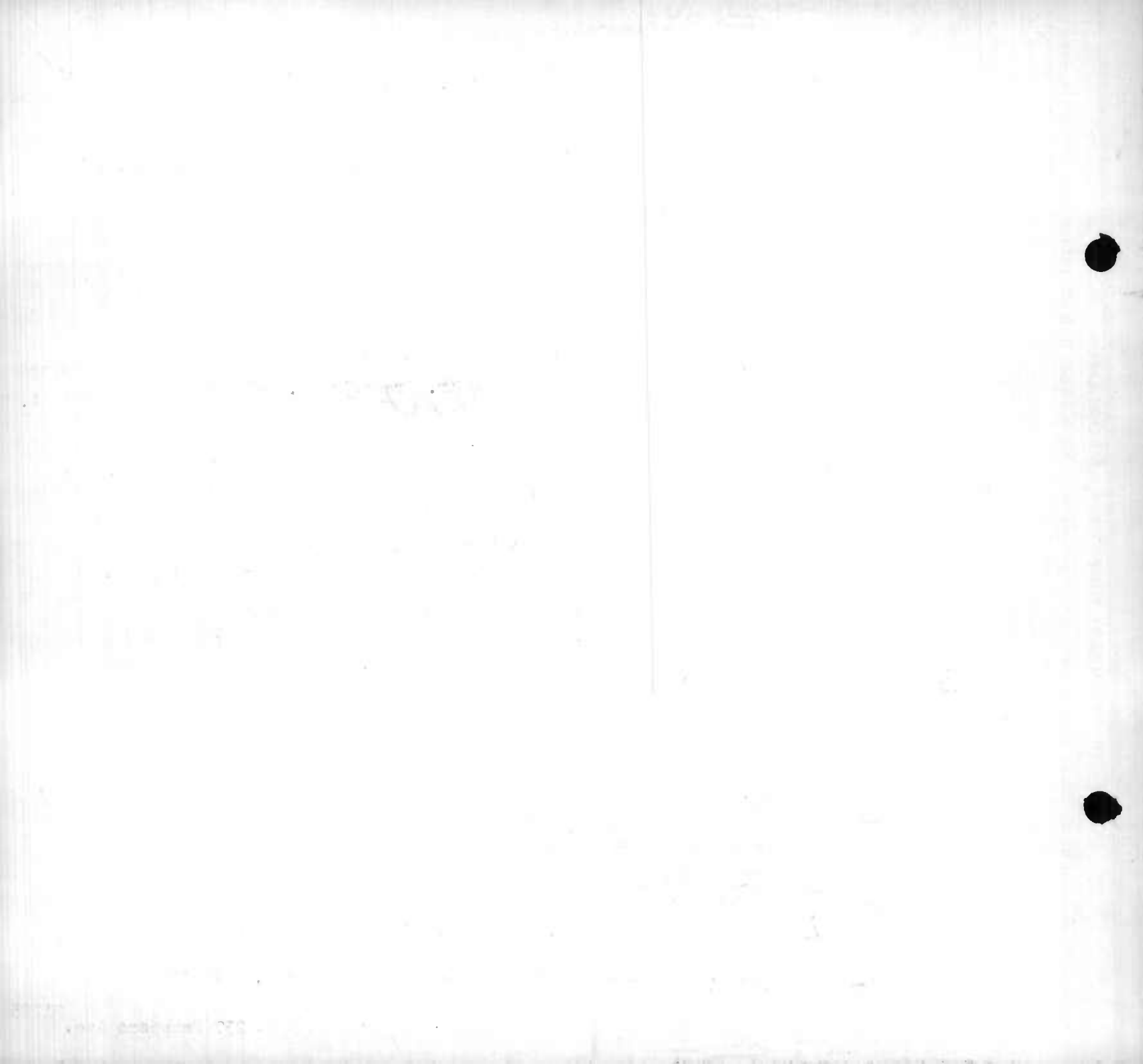
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 67 10266 | | CERTIFICATE OF DEATH | | Registered No. 67 10266 | |
|---|-------------------------|---|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) Heitmann, Mrs. Jane E. | | | | 2. DATE AND HOUR OF DEATH
Oct. 28, 1967 1:40/P M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
49 North Charles General Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY -
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore City, Md 21226
D. STREET ADDRESS (If rural, give location)
1522 Hazel St. 25-05 | | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married | | 8. DATE OF BIRTH
1/31/03 | 9. AGE (In years last birthday)
64 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Penna (Pittsburgh) | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | | |
| 13. FATHER'S NAME
?? Hardy | | | | 14. MOTHER'S MAIDEN NAME
Mary Ellen Aundsbenger | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mr. Frederick C. Heitmann | | ADDRESS 21226 1522 Hazel St. | | | |
| 18. 340.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

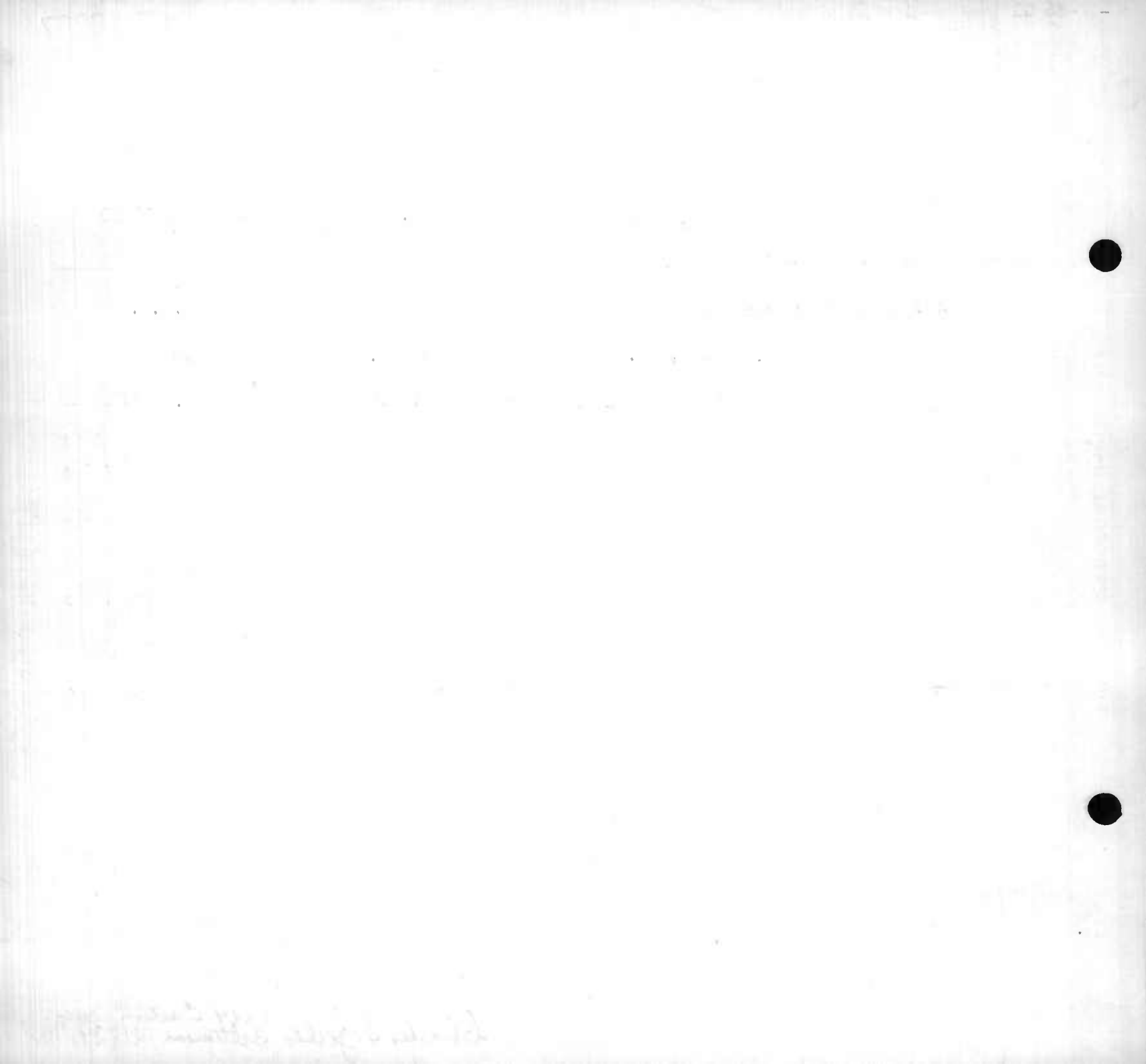
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
= Myocardial Infarction = 1956 Sinai Hospital
= GI Hemorrhage 20 to duodenal Ulcer 1966 JH4 | | | | CAUSE OF DEATH
Septic Shock - Congestive Heart Failure (4th cardiac Arrest)
(A) DUE TO 10/12/67 - subtotal gastrectomy
(B) DUE TO 10/25/67 - Right Anterior Subphrenic Abscess
(C) Chronic Duodenal Ulcer
7 Episode Hemorrhage - malol failure | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
10/25/67 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Chronic Duodenal Ulcer | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (did) attended the deceased from Sept. 25 19 67 to Oct. 28 19 67 , that (I) (was) last saw the deceased alive on Oct. 28 19 67 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Leonard H. Flax, M.D. | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
Oct. 28 '67 | |
| 23C. PHYSICIAN'S NAME (Type)
Leonard H. Flax, M.D. | | | | 23D. ADDRESS
2702 N. Charles St. City 21218 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
10/31/67 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Crematory | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
OCT 30 1967 | | | | 25B. NAME OF REGISTRAR
Robert E. Searcy, M.D. | | 25C. FUNERAL DIRECTOR
McCully Funeral Home | | ADDRESS 21225 237 Patapsco Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10267 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10267 | | | |
|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) <i>Eugene M. Wagner</i> | | | | 2. DATE AND HOUR OF DEATH
<i>10/27/67 9:00 AM</i> | | | | | | | |
| 3. PLACE OF DEATH <i>IN BALTIMORE, MARYLAND</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>MARYLAND</i>
B. COUNTY | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MARYLAND</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>BALTIMORE</i> | | | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<i>204 S. CHESTER STREET # 21231</i> | | | | | | | |
| 5. SEX
<i>MALE</i> | | 6. RACE
<i>WHITE</i> | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>MARRIED</i> | | 8. DATE OF BIRTH
<i>4/14/31</i> | | 9. AGE (In years last birthday)
<i>36</i> | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>AIR-CONDITIONING</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>WESTINGHOUSE ELEC.</i> | | | | 11. BIRTHPLACE (State or foreign country)
<i>PENNSYLVANIA</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>JOHN E. WAGNER, SR.</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>MYRTLE L. AUL</i> | | | | Deceased | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>YES KOREAN CONFLICT</i> | | | | 16. SOCIAL SECURITY NO.
<i>071-24-2326 M</i> | | 17. INFORMANT
<i>21224, MARYLAND ADDRESS
RECORDS: BCH 4940 EASTERN AVE. BALTIMORE</i> | | | | | |
| 18. <i>307X 4-002.1</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <i>Delerium Tremens</i>
DUE TO
(B) <i>Acute & Chronic Alcoholism</i>
DUE TO
(C) | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>9 hours</i>
<i>4 years</i> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Severe bilateral Tuberculosis</i> | | | | | | | | <i>25 years</i> | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Oct. 24, 1967</i> to <i>Oct. 27, 1967</i> , that (I) (we) lost saw the deceased alive on <i>Oct 27, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Jeffrey D. Aaronson, M.D.</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
<i>10/27/67</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Jeffrey D. Aaronson</i> | | | | M.D. <i>4940 Eastern Avenue, Baltimore, Maryland 21224</i> | | | | 23D. ADDRESS
<i>Baltimore City Hospitals</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>10/31/67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>MEMORIAL PARK CEMETERY
LEWISTON, NEW YORK</i> | | 24D. LOCATION (City, town, or county) (State)
<i>LEWISTON, NEW YORK</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 30 1967</i> | | | | 25B. NAME OF REGISTRAR
<i>Robert E. Fisher</i> | | | | 25C. FUNERAL DIRECTOR
<i>Charles S. Zeiler</i> | | | |
| | | | | ADDRESS
<i>6224 Eastern Ave. Baltimore, 21224, Md.</i> | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|--|------------------|--|------------------------------|
| 67 10268 | | 67 10268 | | 67 10268 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | Earl Banks, Jr. | | 10-25-67 3:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| Md. Gen. Hosp. | | Md | | G. J. C. | |
| 48 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Severna Park | |
| | | D. STREET ADDRESS (If rural, give location) | | 52-00 | |
| | | Box 261 Rt 2 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| Male | Cauc. | Divorced | 8-27-29 | 38 | U.S.A |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Machinist | | Beth's Steel | | Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Earl Banks, Sr. | | Orpah McLean (dec) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 212262200 | | Patient | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | Pulmonary edema | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Carcinomatous | | | |
| 21. SEMINOMA of testis, resected | | | | | |
| MEDICAL CERTIFICATION | | 20. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 10-17-1967 | | to 10-25-1967 | |
| that (I) (we) last saw the deceased alive on | | 10-25-1967 | | and that in (my) (our) opinion death occurred on the date | |
| and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| George N. Agapitos | | 10-25-67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| CHARLES BLAZER Jr. | | Md. Gen. Hosp. Beth. Ind. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 10/28/67 | | Glen Haven | |
| 24D. LOCATION (City, town, or county) | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR | |
| Glen Burnie, A.H. Ind. | | Robert E. Fink | | Robert S. Barranco | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| OCT 30 1967 | | Robert E. Fink | | Robert S. Barranco | |

1. The Court, Dismissed
 Plaintiff + Defendant
 Bill Barker, Sr.
 Plaintiff
 vs.
 Defendant
 Bill Barker, Jr.
 Defendant
 10-1-1918

Bill Barker, Jr.
 Defendant

1
9-500

67 10269 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 10269

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM J. QUINN

2. DATE AND HOUR PRONOUNCED DEAD

October 27, 1967

6:45 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Filtration Plant, Hillen Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission)

A. STATE

Maryland

B. COUNTY

Baltimore Co

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

7848 Gough Street # 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

December 11, 1904

9. AGE (In years last birthday)

62

If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore City

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William J. Quinn

14. MOTHER'S MAIDEN NAME

Mary McAleer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-18-0342

17. INFORMANT

Francis X. Burns, Sr.

ADDRESS

Same.

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) ~~xxxxxx~~

Hypertensive Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Edward F. Wilson

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

October 27, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

10-30-67.

23C. NAME OF CEMETERY or CREMATORY

New Cathedral Cem.

23D. LOCATION

(City, town, or county)

(State)

4300 Old Frederick Rd., Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 30 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Charles S. Juler

6224 Eastern Ave.

Balto., 21224, Md.

MAILED BY MAIL ROOM

PAID CONTENT

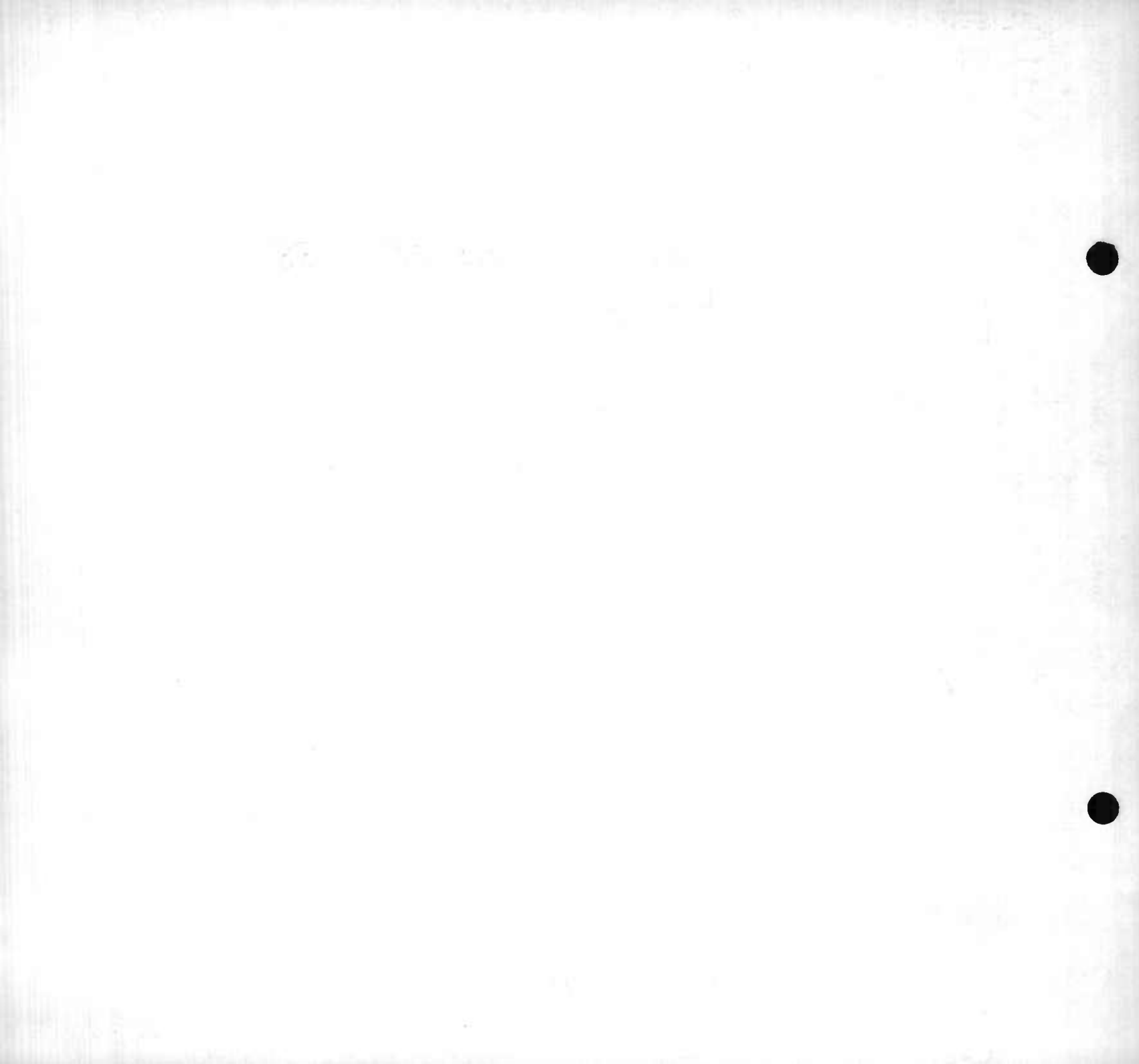
Handwritten signature or initials at the bottom left.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|-------------------------|--|---|--|--|
| 67 10270 | | CERTIFICATE OF DEATH | | 67 10270 | |
| 1. NAME OF DECEASED
(Type or Print) MATTIE LEE STOKES | | | 2. DATE AND HOUR OF DEATH
10-24-67 5:30 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
FRANKLIN SQUARE HOSPITAL
36 BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE BALTIMORE B. COUNTY COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) MIDDLE RIVER 53-00
D. STREET ADDRESS (If rural, give location) 3 RUNWAY COURT | | |
| 5. SEX
F | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
6/5/29 | 9. AGE (In years lost birthday)
38 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
Westing House | | 11. BIRTHPLACE (State or foreign country)
LEXINGTON, N. C. | |
| 13. FATHER'S NAME
LINDSEY CROOK | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
244 28 470 | | 17. INFORMANT
FRANKLIN SQUARE HOSPITAL |
| 18. 199.21
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Cholexia 2° to par - Carcinomatosis
(B) Carcinomatosis
(C) Carcinomatosis | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
10-3-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
INTESTINAL OBSTRUCTION | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 25 19 67 to October 24 19 67 , that (I) (we) last saw the deceased alive on October 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Ruben V. Luna M.D. | | | | 23B. DATE SIGNED
October 24, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
RUBEN V. LUNA | | 23D. ADDRESS
M.D. FRANKLIN SQUARE HOSPITAL, BAL. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
REMOVAL | | 24B. DATE
10/24/67 | | 24C. NAME OF CEMETERY or CREMATORY
GREENWOOD | |
| 24D. LOCATION
TARBORO N.C. | | 24E. LOCATION (City, town, or county) (State) N.C. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
Connelly F.H. | |
| | | | | ADDRESS
300 Maco | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

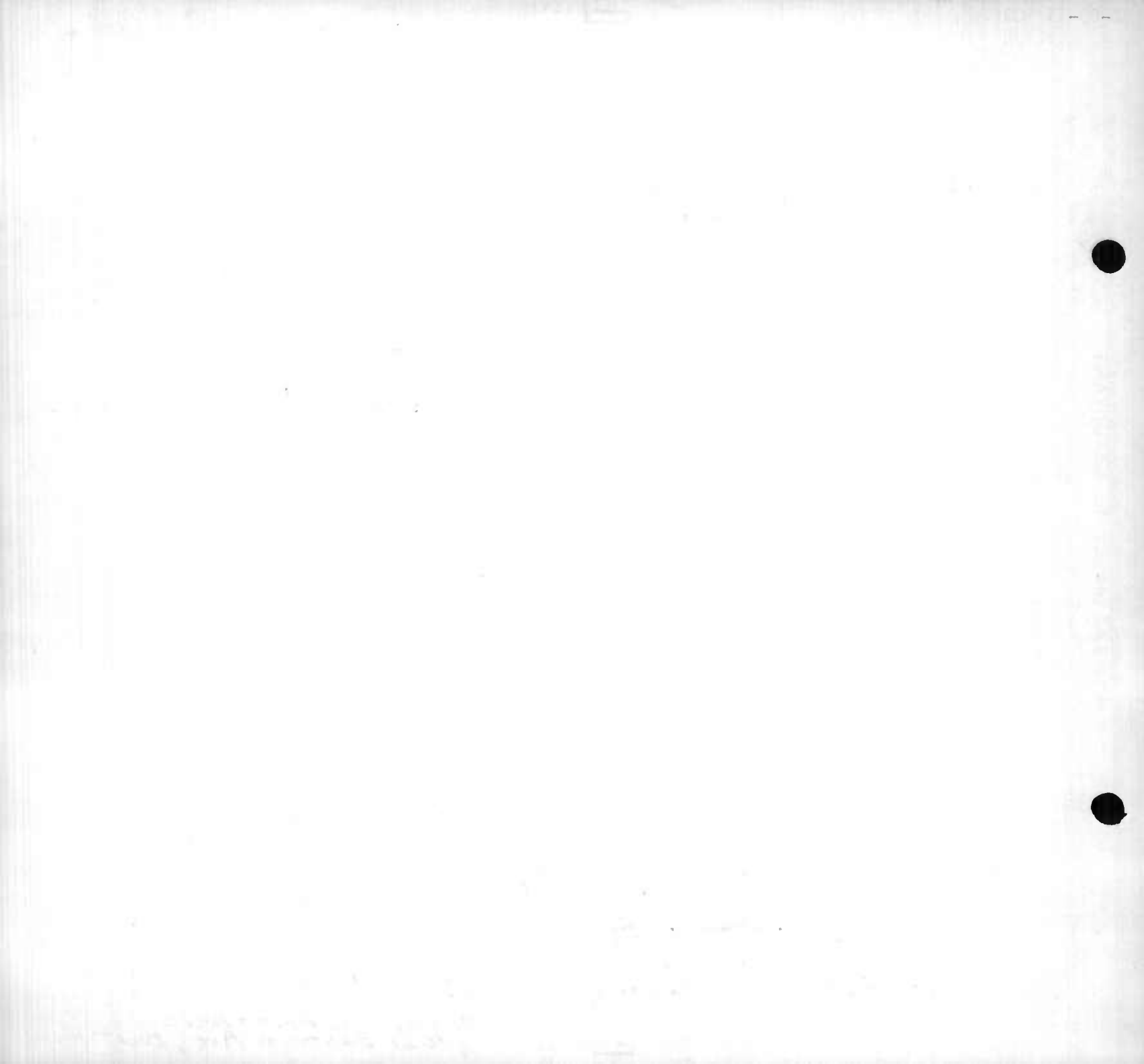
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | 67 10271 |
|---|---------------------|---|--|--|---|
| BIRTH NO.
67 10271 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print)
LINDOS, MRS. FOTINE | | | 2. DATE AND HOUR OF DEATH
10-25-67 5 45 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
CHURCH HOME & HOSPITAL
35
(If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE
MD
B. COUNTY
527 S. NEWKIRK ST., (24)
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE, M.D.
D. STREET ADDRESS (If rural, give location)
26-07 | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | B. DATE OF BIRTH
8-3-99 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
GREECE | | 12. CITIZEN OF WHAT COUNTRY?
U.S. |
| 13. FATHER'S NAME
DIMITRI SPANOUDIS | | | 14. MOTHER'S MAIDEN NAME
MARY SAUTS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
212-36-1392 | 17. INFORMANT
James Lindos
527 S. Newkirk St., Baltimore, Md. | | |
| 18. 492 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)
SEPTICEMIA
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
RENAL FAILURE
PNEUMONITIS | | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-16 19 67 to 10-25 19 67 , that (I) (we) last saw the deceased alive on 10-25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
James Y. O'Leary | | | | 23B. DATE SIGNED
10-25-67 | |
| 23C. PHYSICIAN'S NAME (Type)
James Y. O'Leary | | | | 23D. ADDRESS
M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/28/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Greek Orthodox Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher, Md. | | 25C. FUNERAL DIRECTOR
Nicholas T. Matthews
3021 Eastern Ave., Baltimore, Md. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|------------------------------------|--|--|
| BIRTH NO. 67 10272 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10272 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Miller, Laura | | 2. DATE AND HOUR OF DEATH
10/24/67 4²⁵ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore BALTIMORE 26-44 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MARYLAND | | D. STREET ADDRESS (If rural, give location)
111 N. Gunney St | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
10/1/96 | 9. AGE (In years lost birthday)
71 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
ELMER MOOREHEAD | | 14. MOTHER'S MAIDEN NAME
ABIGAIL SHARTTLE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
21224, MARYLAND
RECORDS: BCH 4940 EASTERN AVENUE BALTIMORE | |
| 18. 334 X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cerebrovascular dis. | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
10/24/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
NO | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 10/16/67 19 to 10/24/67 19 | | that (I) (we) last saw the deceased alive on 10/24/67 19 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE
Robert N. Hill M.D. | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type)
DR. ROBERT N. HILL | |
| 23D. ADDRESS
BALTIMORE 21224, MARYLAND
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE | | 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
10/27/67 | |
| 24C. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 24D. LOCATION
(City, town, or county) (State)
Baltimore, Md. | | 25A. DATE RECEIVED BY HEALTH/DEPT.
OCT 30 1967 | |
| 25B. NAME OF REGISTRAR
Robert E. Fink | | 25C. FUNERAL DIRECTOR
Nicholas J. Matthews | | ADDRESS
3021 Eastern Ave, Baltimore | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 67 10273 | |
|--|------------------------------|---|---|--|--|
| BIRTH NO. 67 10273 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MURIEL C. FORD | | 2. DATE AND HOUR OF DEATH
10/26/67 5:10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE md. B. COUNTY Carroll Co. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
35 Church Home & Hosp. Balto, 31, md. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Westminster 56-00 | | | |
| | | D. STREET ADDRESS (If rural, give location)
Rd #5 211 57 | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED DIVORCED (specify) | 8. DATE OF BIRTH
5/14/24 | 9. AGE (In years last birthday)
43 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Repair Clerk C&P Telephone Co | | 10B. KIND OF BUSINESS OR INDUSTRY
md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James R. Clark | | 14. MOTHER'S MAIDEN NAME
Ethelyn Crutledge | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216 16 9145 | | 17. INFORMANT
Mr. Francis J. Ford RFD #5 Box 167C Westminster Md | |
| 18. I
17 IX I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO
CARCINOMA of CERVIX UTERI | | 18 mos. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
Nov. 1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma of Cervix | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (s) (this hospital) attended the deceased from 10/16/67 to 10/26/67 , that (s) (we) last saw the deceased alive on 10/26/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Francisco Baltazar M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED
10/26/67 | |
| 23C. PHYSICIAN'S NAME (Type)
FRANCISCO BALTAZAR M.D. | | 23D. ADDRESS
Church Home & Hosp. 100 N. Broadway Balto, md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
10/30/67 | 24C. NAME OF CEMETERY or CREMATORY
Lakeriew Memorial | 24D. LOCATION (City, town, or county) (State)
Liberty Rd Carroll Co. Md | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Spring Byers Randallstown Md | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 10274</u> | |
|---|-----------------------------|--|--|--|---|
| BIRTH NO. <u>67 10274</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. <u>1</u> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>SUMMERS, T. ROLAND</u> | | | 2. DATE AND HOUR OF DEATH
<u>10/26/67</u> <u>3.05 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>46 LUTHERAN HOSPITAL</u> | | | A. STATE <u>MD.</u>
B. COUNTY | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> <u>16-03</u> | | |
| | | | D. STREET ADDRESS (If rural, give location)
<u>1621 LAURENS ST.</u> | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Caucasoid</u> | 7. MARRIED, NEVER MARRIED
<u>Widowed</u> | 8. DATE OF BIRTH
<u>Oct. 2 1895</u> | 9. AGE (In years last birthday)
<u>72</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Labourer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Stable man</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Carroll Co. Md. U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Thomas Summers</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Anna Elizabeth Diggs</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
<u>212-14-7997</u> | | 17. INFORMANT
<u>Mrs. Beatrice L. Frisby</u> |
| 18. <u>443 X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
<u>CEREBRAL HEMORRHAGE</u>
ONE DAY | | | CAUSE OF DEATH
(A) DUE TO
<u>HASCV</u>
YEARS
(B) DUE TO
(C) | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> <u>1967</u> to <u>10/26</u> <u>1967</u> , that (I) (we) lost saw the deceased alive on <u>10/26</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>F. Queral</u> | | | | 23B. DATE SIGNED
<u>10/26/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>F. QUERAL</u> | | | | 23D. ADDRESS
<u>LUTHERAN HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>10/29/67</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>St. James Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Rural near Windsor, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 30 1967</u> | | | |
| 25B. NAME OF REGISTRAR
<u>John E. F. F. F.</u> | | 25C. FUNERAL DIRECTOR
<u>J. E. Myers, Jr., Westminster, Md.</u> | | | |

100-100-100

100-100-100

100

BALTIMORE

LUTHERAN HOSPITAL

1621 LAURENCE ST

DET 3 1972 72

MR. CLARK (MURDER)

LABORATORY OF THE DISTRICT ATTORNEY

LABORATORY OF THE DISTRICT ATTORNEY

212-14-1997 (see Section 9) (see Section 9)

CEREBRAL HEMORRHAGE

HASCA

22-1-72

10/50

10/52

61

10/51

X

10/52/10

F. QUERAR

LUTHERAN HOSPITAL

10/51/72

10/51/72

10/51/72

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10275 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10275 | | | |
|---|---------|--|------------------|--|-----------------------|-----------------------|------------------------|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | | | 2. DATE AND HOUR OF DEATH | | | |
| (Type or Print) | | | | SAMUEL M. JENNESS | | | | OCTOBER 26, 1967 8:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | | | | | |
| University of Maryland Hospital | | | | MARYLAND CARROLL Co. | | | | | | | |
| 38 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | WESTMINSTER 56-27 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 34 FITZHUGH AVE | | | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | | | |
| Male | White | Married | 12/26/00 | 66 | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| Board of Education Co. | | | | Superintendent of Schools | | | | MARYLAND | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| U. S. A. | | | | William T. Jenness | | | | Harriett McCordell | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | |
| Unknown | | | | 216-22-8741 | | | | Mrs Samuel M. Jenness | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | ADDRESS | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Bilateral Adrenal Tumors | | | | Same address | | | |
| ANTECEDENT CAUSES | | | | (B) Solitary Renal Tumor, left lower Pole | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) Electrolyte Imbalance with Hypercalcemia | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | |
| 2 | | | | | | | | Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from October 20, 1967 to October 26, 1967, that (I) (we) last saw the deceased alive on October 25, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (do) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | 23B. DATE SIGNED | | | |
| Richard H. Bard | | | | | | | | October 26, 1967 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | 23D. ADDRESS | | | |
| Richard H. Bard | | | | | | | | University of Maryland Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | | 24C. NAME OF CEMETERY or CREMATORY | | | |
| Burial | | | | 10/29/67 | | | | Meadow Branch Cem. Rural Westminster, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR | | | |
| OCT 30 1967 | | | | Robert E. Fairbank | | | | J. E. Myers, Jr., Westminster, Md. | | | |

October 22, 1952

University of Maryland Hospital

WESTMINSTER

34 FITZGERALD AVE

12/22/50

Male White Married

Board of Education of Baltimore City

William T. Jones

Harriet McConell

H-2-A

Unknown

Bilateral Adrenal Tumors

Left renal tumor, left lower pole

Endocrine Imbalance with Hypertension

Yes Yes

October 22, 1952

Richard H. Bond

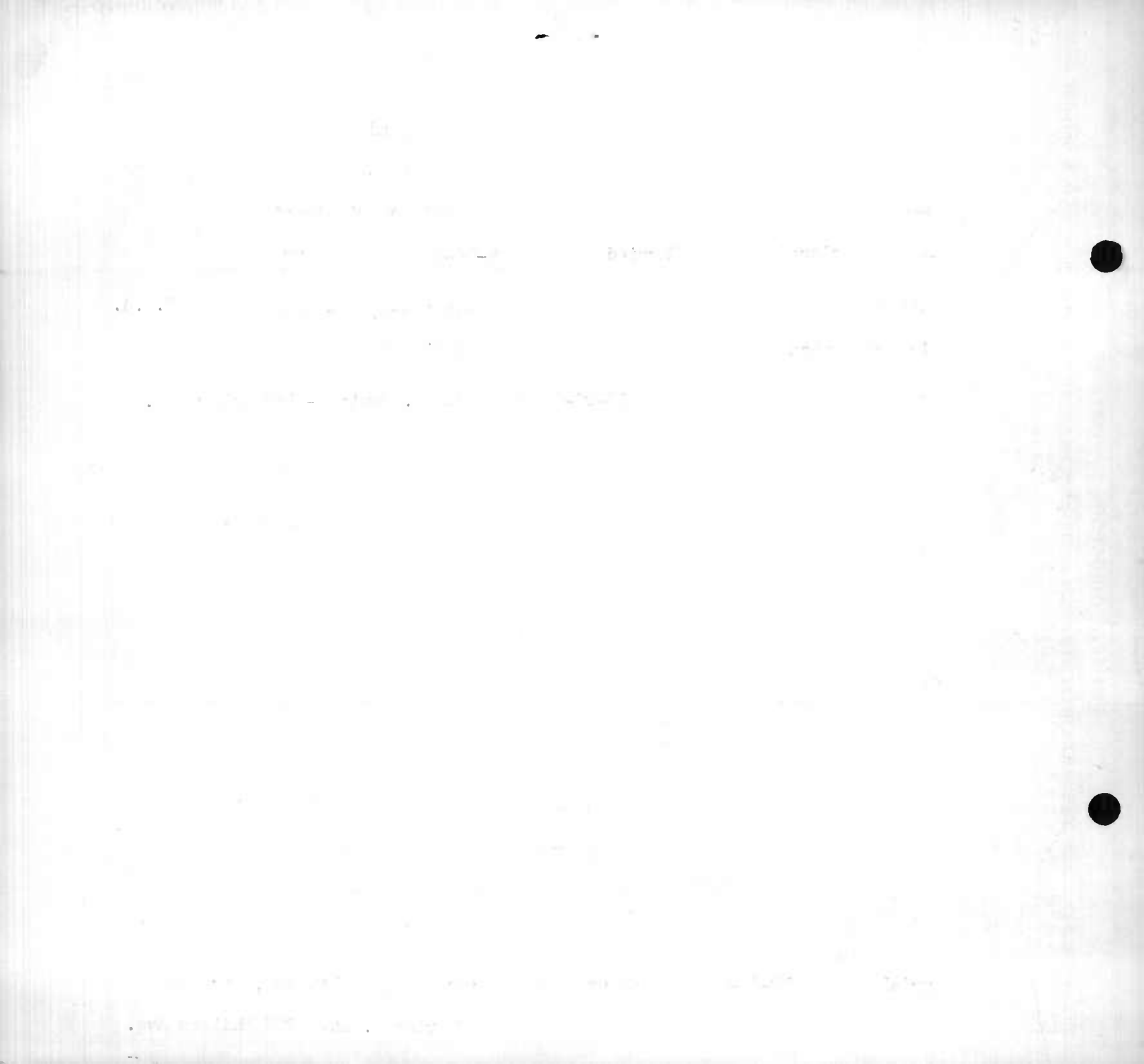
Richard H. Bond

University of Maryland Hospital

For Mr. Jones, Board of Education of Baltimore City

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------------|--|-------------------------------|---|---|
| BIRTH NO. 67 10276 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10276 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) CHAPELTON, NEWTON | | 2. DATE AND HOUR OF DEATH
10/27/67 1 345 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Sinai Hospital of Baltimore
422 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | 14-01 | |
| | | D. STREET ADDRESS (If rural, give location)
255 Robert Street | | | |
| 5. SEX
Male | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
9-28-1890 | 9. AGE (In years lost birthday)
77 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Waiter | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Richard Newton | | 14. MOTHER'S MAIDEN NAME
Annie Grey | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-05-0018 | | 17. INFORMANT ADDRESS
Edna B. Newton - 255 Robert St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.1 I
MYOCARDIAL INFARCTION
DUE TO
Anterior Septal Coronary artery disease
UNKNOWN
INTERVAL BETWEEN ONSET AND DEATH
48 HRS | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pneumonia | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/25 19 67 to 10/27 19 67, that (I) (we) last saw the deceased alive on 10/27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Kenneth Wetcher | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
KENNETH WETCHER | | M.D. | | 23D. ADDRESS
Sinai Hospital of Balto. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-30-67 | | 24C. NAME of CEMETERY or CREMATORY
Arbutus Memorial Park | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. CITY, town, or county
(State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Charles E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS
Charles R. Law 802 Madison Ave. | |



CERTIFICATE OF DEATH

Registered No.

67 10277

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Knight Walter

2. DATE AND HOUR OF DEATH

10-27-67

11:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2309 ROSLYN AVENUE

#21216

5. SEX

M

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

10-26-92

9. AGE (In years
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Rigger

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN KNIGHT

14. MOTHER'S MAIDEN NAME

CLARA JACKSON

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

218-07-1609

17. INFORMANT

ADDRESS

21224

RECORDS-BCH#4940 EASTERN AVENUE-BALTIMORE, MD

18. 493 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)

(A) Pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

ASCVD

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-28 19 67 to 10-27-19 67,
that (I) (we) last saw the deceased alive on 10-27 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

10-27-67

23C. PHYSICIAN'S
NAME (Type)

Roy S. Weiner

M.D.

23D. ADDRESS

BCH-4940 EASTERN AVENUE-BALTIMORE, MD 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

24B. DATE

10/30/67

24C. NAME of CEMETERY or CREMATORY

FamilyLot Cemetery

24D. LOCATION

(City, town, or county)

Crewe Va. Nottaway County

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 30 1967

25B. NAME OF REGISTRAR

Robert E. Fisher

25C. FUNERAL DIRECTOR

Herbert E. Nutter 3035 W. North Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

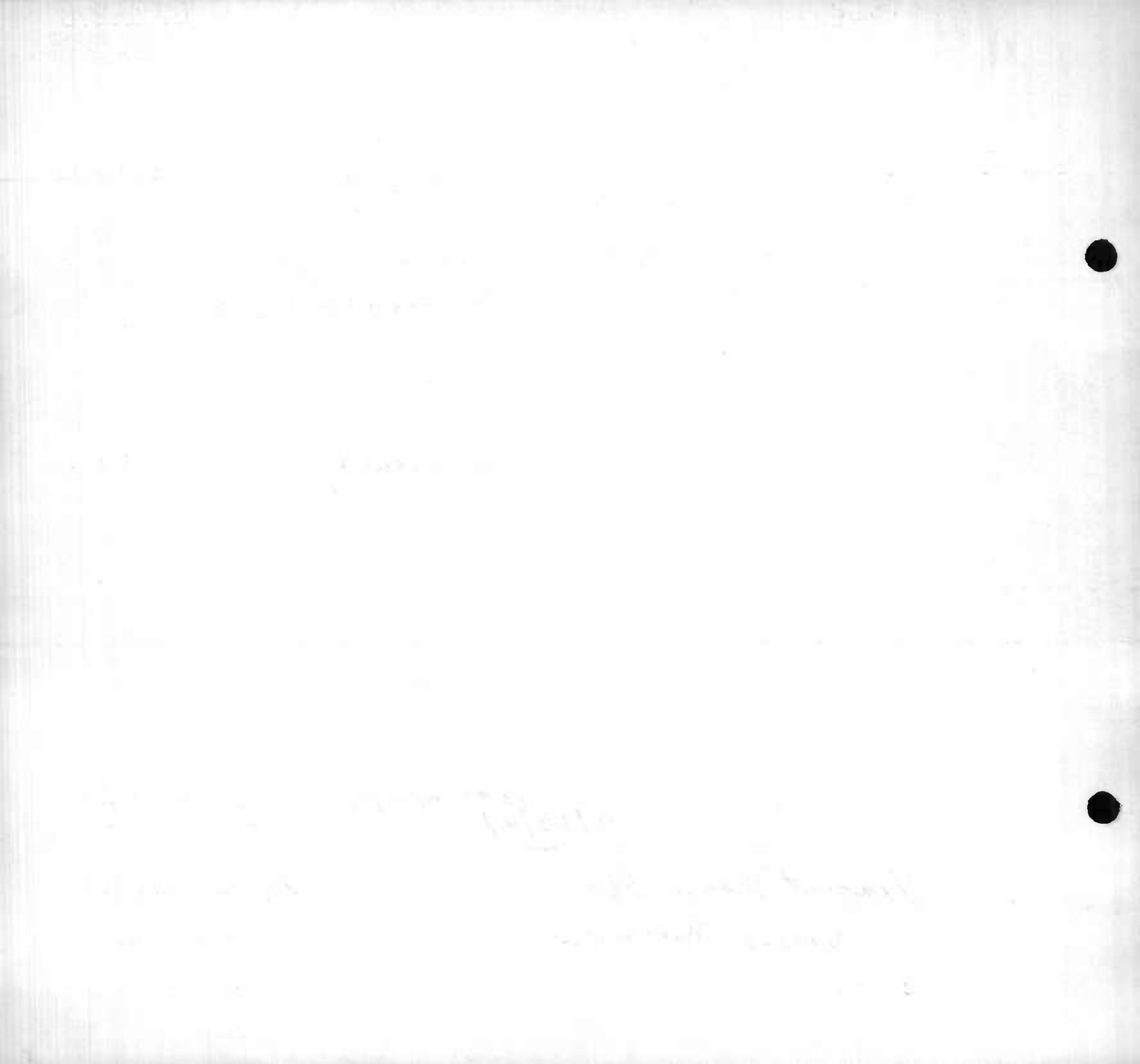
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 10278 | |
|--|-----------|--|--------------------------|--|--|
| BIRTH NO. <u>67-21586</u> <u>67 10278</u> | | CERTIFICATE OF DEATH | | Registered No. <u>67 10278</u> | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Baby Girl of Lavern Demby | | 10-23-67 5:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

The Johns Hopkins Hospital | | A. STATE | | B. COUNTY | |
| | | Maryland | | A.A. | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Glen Burnie | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | Route 1, Box 90 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| F | Negro | Infant | 10-23-67 | | 5 30 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Johns Hopkins Hospital | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| David Demby | | | Lavern Spencer | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | 5 1/2 hrs | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12 PM 10/22/67</u> 19 to <u>5:30 AM 10/23/67</u> 19, that (I) (we) last saw the deceased alive on <u>10/23/67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Vincent Manganiello | | | | 10/23/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| VINCENT MANGANIELLO M.D. | | JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Cremation | 10-23-67 | Johns Hopkins Hospital | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| OCT 30 1967 | | Robert E. Taylor | | HOSPITAL DISPOSAL | |



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN L. SPEALMAN

2. DATE AND HOUR PRONOUNCED DEAD

October 26, 1967

7:10 pm.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Church Home & Hospital D.O.A.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

102 N. Luzerne Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11/25/1890

9. AGE (in years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Conductor

10B. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Spealman

14. MOTHER'S MAIDEN NAME

Mary Bohs

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

705-10-9618

17. INFORMANT

ADDRESS

Mrs. Margaret E. Spealman 102 N. Luzerne

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) ~~XXXXXX~~Arteriosclerotic Cardiovascular
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT ☐
WORKNOT WHILE ☐
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 27, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/30/1967

23C. NAME OF CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 30 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

John A. Moran Inc. 3000 E. Baltimore St.

... fact.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Non Med. Released for the Medical Examiners Office by Dr. Springate
MEDICAL CERTIFICATION

| | | | | | | | |
|---|-------------------------|--|------------------------------------|---|--|---|-----------------------|
| BIRTH NO. 20 | | 67 10280 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10280 | |
| 1. NAME OF DECEASED
(Type or Print) John Brooks | | | | 2. DATE AND HOUR OF DEATH
10-26-67 3:06 p. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
The Johns Hopkins Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| D. STREET ADDRESS (If rural, give location)
2617 Preston Street | | | | 8-03 | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
11/9/16 | 9. AGE (In years last birthday)
50 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Robert Brooks | | | | 14. MOTHER'S MAIDEN NAME
Mary Walker | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT
Edworth Brooks 2617 E. Preston | | | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
420.1 I | | CAUSE OF DEATH
Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. | | 19. MEDICAL EXAMINER'S CASE
NOT A MEDICAL EXAMINER'S CASE
CHIEF OR ASST. MEDICAL EXAMINER | | 20. MEDICAL EXAMINER'S CASE
NOT A MEDICAL EXAMINER'S CASE
CHIEF OR ASST. MEDICAL EXAMINER | | 21. MEDICAL EXAMINER'S CASE
NOT A MEDICAL EXAMINER'S CASE
CHIEF OR ASST. MEDICAL EXAMINER | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DOA 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
John T. Flaherty | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10-27-67 | |
| 23C. PHYSICIAN'S NAME (Type)
John T. Flaherty | | | | 23D. ADDRESS
The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10/30/67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary | | 24D. LOCATION (City, town, or county) (State)
A.A. Co Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farber | | 25C. FUNERAL DIRECTOR
MARSHALL W. JONES, Jr | | 1735 ADDRESS
HARFORD AVE | |

FUNERAL DIRECTOR: IMPORTANT

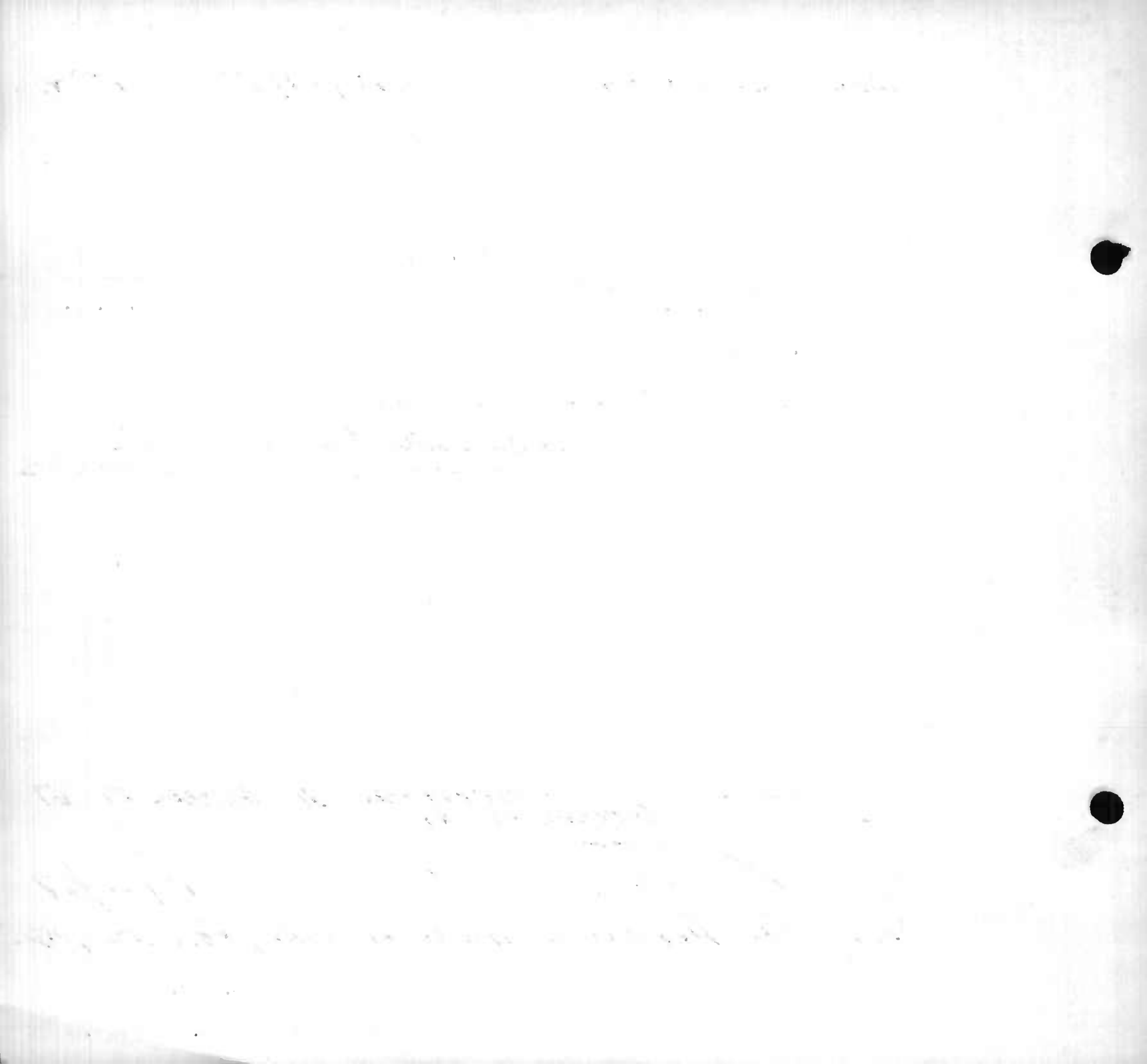
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10281 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10281 | |
|---|-------------------------|---|---|--|---|
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) JOHN Joseph RILEY | | 2. DATE AND HOUR OF DEATH
10/27/67 7:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

43 South Baltimore General Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 24-02
D. STREET ADDRESS (If rural, give location)
1422 Jackson Street | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
Nov. 29, 1924 | 9. AGE (In years lost birthday)
42 | 10. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chief Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY
W. M. Railway | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 13. FATHER'S NAME
John G. Riley | | | 14. MOTHER'S MAIDEN NAME
Vera Serra | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
Yes W W 11 | | 16. SOCIAL SECURITY NO.
218-18-7065 | | 17. INFORMANT ADDRESS
Miss Lillian Riley 21230
1422 Jackson Street | |
| 18. CAUSE OF DEATH
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

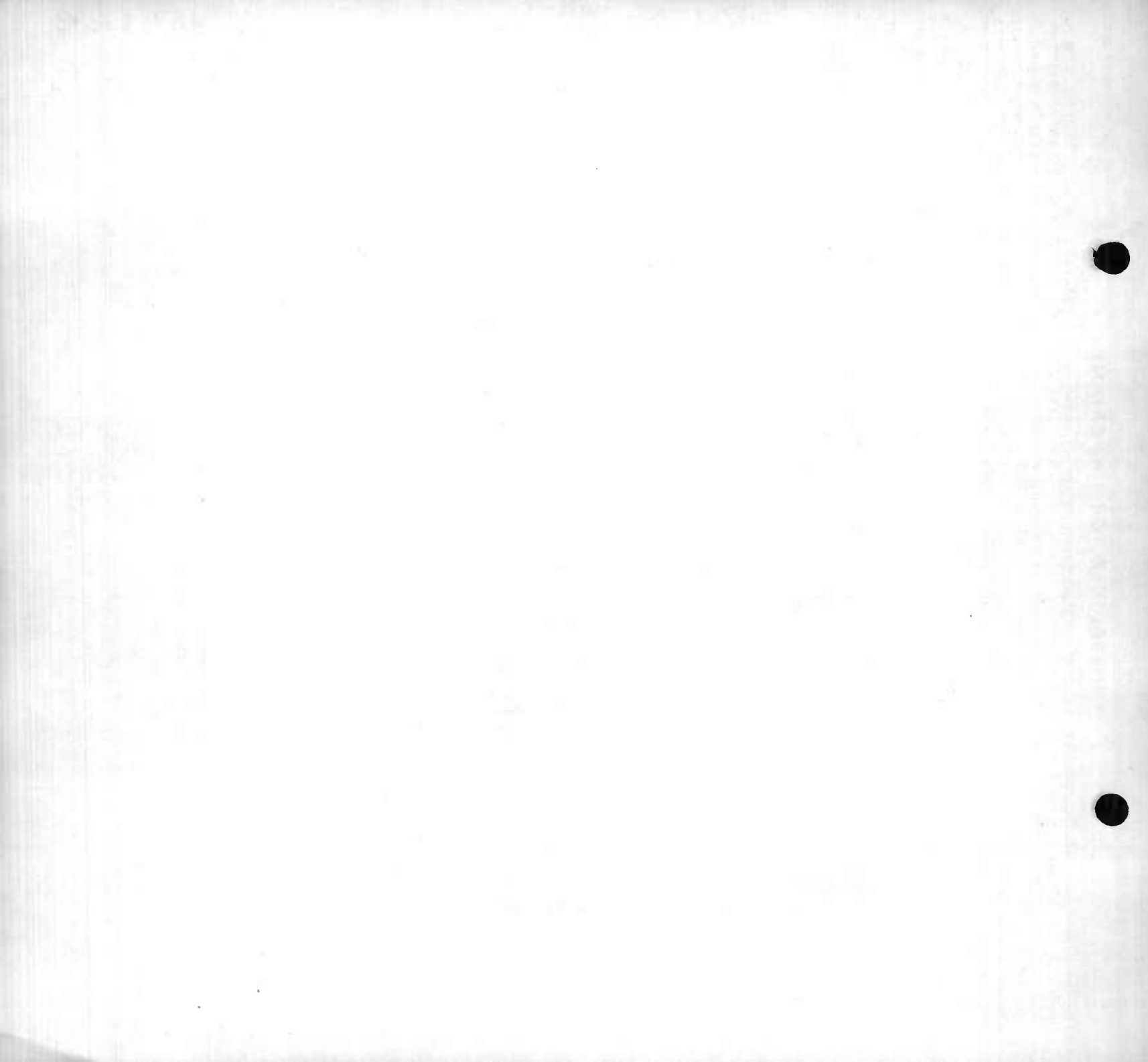
 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> INTERVAL BETWEEN ONSET AND DEATH
 2 months </div> </div> <div style="margin-top: 10px;"> II
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. </div> | | | | | |
| MEDICAL CERTIFICATION
19A. DATE OF OPERATION 1967 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 67 to OCTOBER 27 19 67 that (I) (we) last saw the deceased alive on OCTOBER 27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Colen C. Heineltz M.D. | | | | 23B. DATE SIGNED
10/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
COLEN C. HEINELTZ | | 23D. ADDRESS
1916 BELAIR ROAD, FALLSTON, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/30/67 | | 24C. NAME of CEMETERY or CREMATORY
Gardens of Faith | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. OCT 30 1967 25B. NAME OF REGISTRAR Robert E. Farber, M.D. 25C. FUNERAL DIRECTOR McCully F.H. ADDRESS 130 E. Fort Ave. 21230 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------|---|------------------|--|--|
| 67 10282 | | Baltimore City Health Department | | Registered No. 67 10282 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | MR. C. FRED Bitzberger | | October 26 1967 10:50 A.M. | |
| M.E. CASE NO. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | |
| | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland Gen. Hospital
48 | | A. STATE
MD
B. COUNTY
Baltimore
15-11 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| M | W | MARRIED | Feb. 14 1884 | 83 | Linotypist |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| | | | | Pa. | U.S. |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| FRED Bitzberger | | ? UNKNOWN | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 212-30-1538 | | Nettie Bitzberger - Same | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 451X I
Ruptured abdominal aortic aneurysm. | | | | Oct 26 1967
Oct 26 1967 | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| Oct 26 1967 | | Critical | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| No | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> At Home <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from October 26 1967 to October 26 1967, that (I) (we) last saw the deceased alive on Oct 26 1967 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. | | 23B. DATE SIGNED | |
| Youngsick Moon | | <input type="checkbox"/> | | Oct 26 1967 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| YOUNGSICK MOON | | Maryland Gen. Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 10-30-67 | | Woodlawn Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| OCT 30 1967 | | P. C. & E. Johnson | | Ellsworth Armacost - 4600 Liberty Heights | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10283 | |
|---|-------------------------|--|------------------------------------|--|--|
| BIRTH NO. 67 10283 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Joie Baldwin | | 2. DATE AND HOUR OF DEATH
10-23-67 9:40 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 22-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
43 South Baltimore General Hosp | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore # 21230 | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location)
206 So. Hanover St. | | | |
| 5. SEX
M | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Divorced | 8. DATE OF BIRTH
9-15-24 | 9. AGE (In years last birthday)
43 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown | | 10B. KIND OF BUSINESS OR INDUSTRY
NONE | | 11. BIRTHPLACE (State or foreign country)
Oklahoma | |
| 13. FATHER'S NAME
Joe | | 14. MOTHER'S MAIDEN NAME
Elsie | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW II | | 16. SOCIAL SECURITY NO.
446-209011 | | 17. INFORMANT
Manuel McStacken | |
| 18. 49.3 X I | | CAUSE OF DEATH | | ADDRESS
128 Light St. Balt., Md. | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Gram Negative Septicemia
DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Urinary Tract Infection
DUE TO generalized debilitation | | | |
| | | (C) Pt. had 2 Cardiac arrests
Pneumococcal Pneumonia | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (if) (this hospital) attended the deceased from 9-23 1967 to 10-23 1967 , that (if) (we) last saw the deceased alive on 10-23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Donald M. Wood M.D. | | | | 23B. DATE SIGNED
10-24-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Donald M. Wood M.D. | | | | 23D. ADDRESS
1213 Light St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-31-1967 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore Nat. Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Balt., Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
Oct 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Wm. Cook-Brooks, Inc. | |
| | | | | ADDRESS
1217 St. Paul St. Balt. Md. | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10284

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)ARCHIE ~~XXXXXX~~ JESSIE KING, SR.

2. DATE AND HOUR PRONOUNCED DEAD

October 26, 1967 6:20 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1607 St. Paul St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 1, 1898

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Tennessee

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Anderson King

14. MOTHER'S MAIDEN NAME

Alice Mc Laughlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.I

16. SOCIAL
SECURITY NO.

415-03-8645

17. INFORMANT

ADDRESS

Archie J. King, Jr. 1607 St. Paul St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive and Arteriosclerotic

X X X X

Cardiovascular Disease

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 26, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10-31-67

10-30-67

23C. NAME OF CEMETERY or CREMATORY

Prospect Hill Cemetery

Baltimore National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Towson, Maryland

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

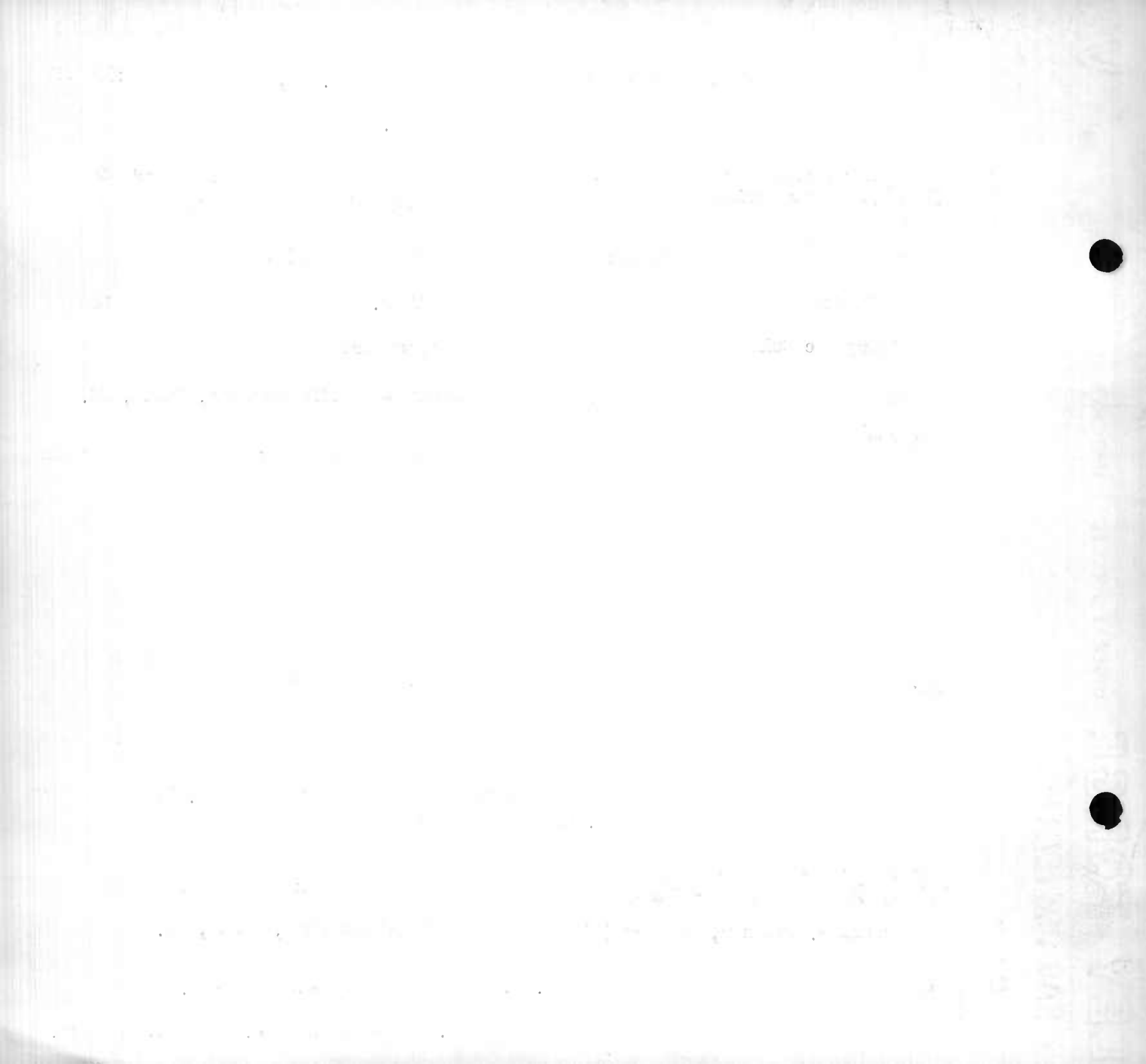
24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks, Inc. 1217 St. Paul St.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10285 | |
|--|--|---|--|----------------------------------|-----------------------------|
| BIRTH NO. 67 10285 | | CERTIFICATE OF DEATH | | Registered No. 67 10285 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Roberta Lynn Mc Collum | | Oct. 27, 1967 9:35 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| US Public Health Service Hospital | | Va. | | | |
| 3100 Wyman Park Drive | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Springfield | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 5408 Glenallen street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| F | W | Single | 11/12/53 | 13 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| Student | | | Tenn. | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| George Mc Collum | | Amanda Ford | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| no | | none | Records- US PHS Hospital, Balto, Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 2043 I | | Acute lymphocytic leukemia | | Months | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 2 | | yes | yes | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from July 27 19 67 to Oct. 27 19 67, that (1) (we) last saw the deceased alive on Oct. 27 19 67 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Michael E. Pelczar M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 10/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Michael E. Pelczar, SA Surg (R) M.D. | | US PHS Hospital, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Removal | 10/27/67 | Delo-Taylor F. H. | Waynesboro, Tenn. | | |
| 25A. DATE REC'D BY HEALTH DEPT | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| Oct 30 1967 | Robert E. Taylor, M.D. | Wm. Cook-Brooks, Inc. 1217 St. Paul St. | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)JOHN ~~MCCOMAS~~ RICHARD MC COMAS

2. DATE AND HOUR PRONOUNCED DEAD

October 25, 1967 8:53 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)33
99 Johns Hopkins Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

411 Pitman Place

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 16, 1927

9. AGE (in years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Mc Comas

14. MOTHER'S MAIDEN NAME

Rose Meehan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). If yes, give war or dates of service)

Yes

W.W. II

16. SOCIAL
SECURITY NO.

214-20-9781

17. INFORMANT

ADDRESS

Mrs. Margaret E. Mc Comas 411 Pitman Place

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hemoperitoneum
DUE TO

Ruptured spleen

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Cardiovascular Disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

411 Pitman Place

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

10 20 67 ?

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject fell at home

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

October 26, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/30/67

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery Baltimore, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

OCT 30 1967

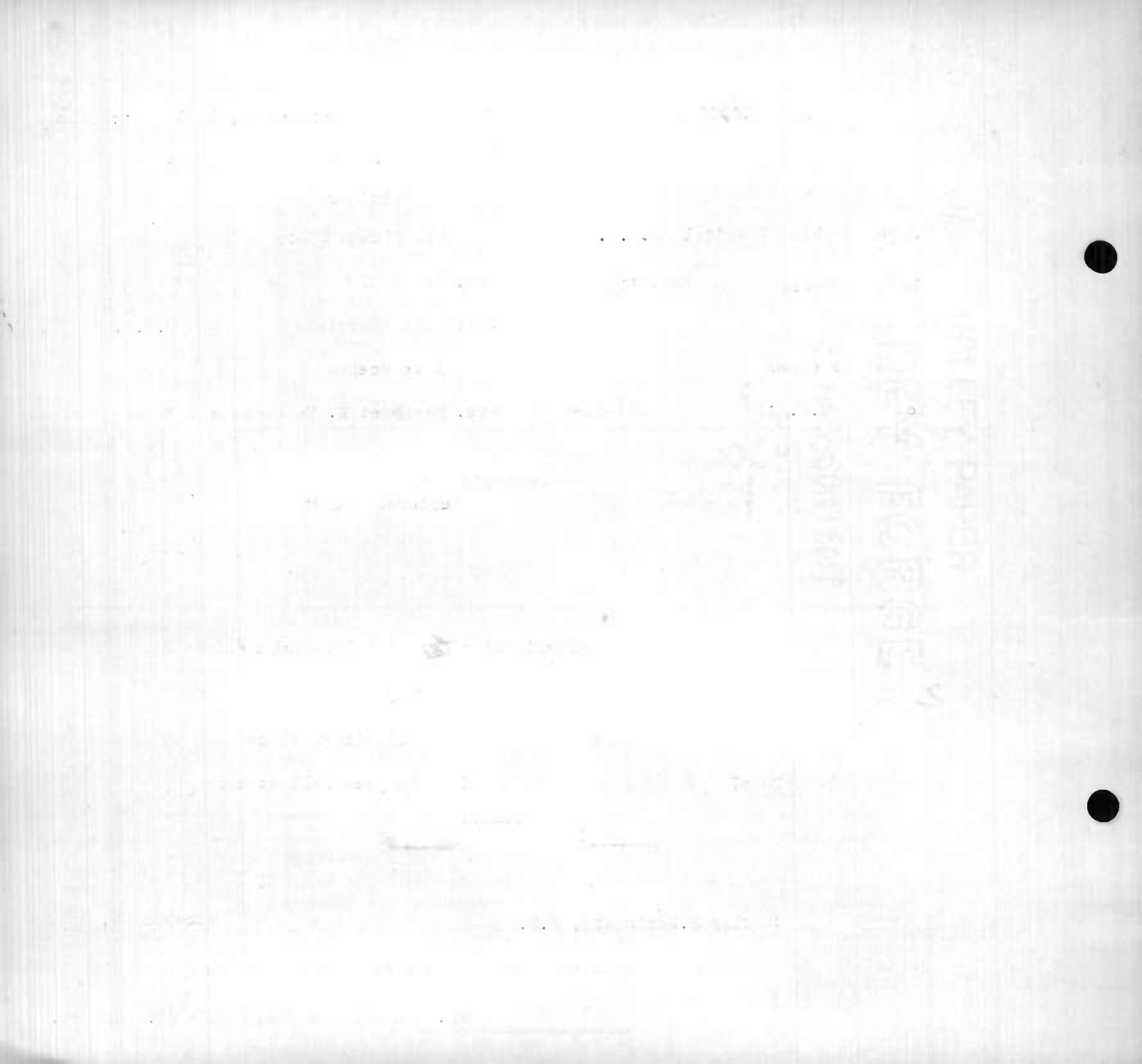
24B. NAME OF REGISTRAR

Robert E. Fairbanks

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks, Inc, 1217 St. Paul St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

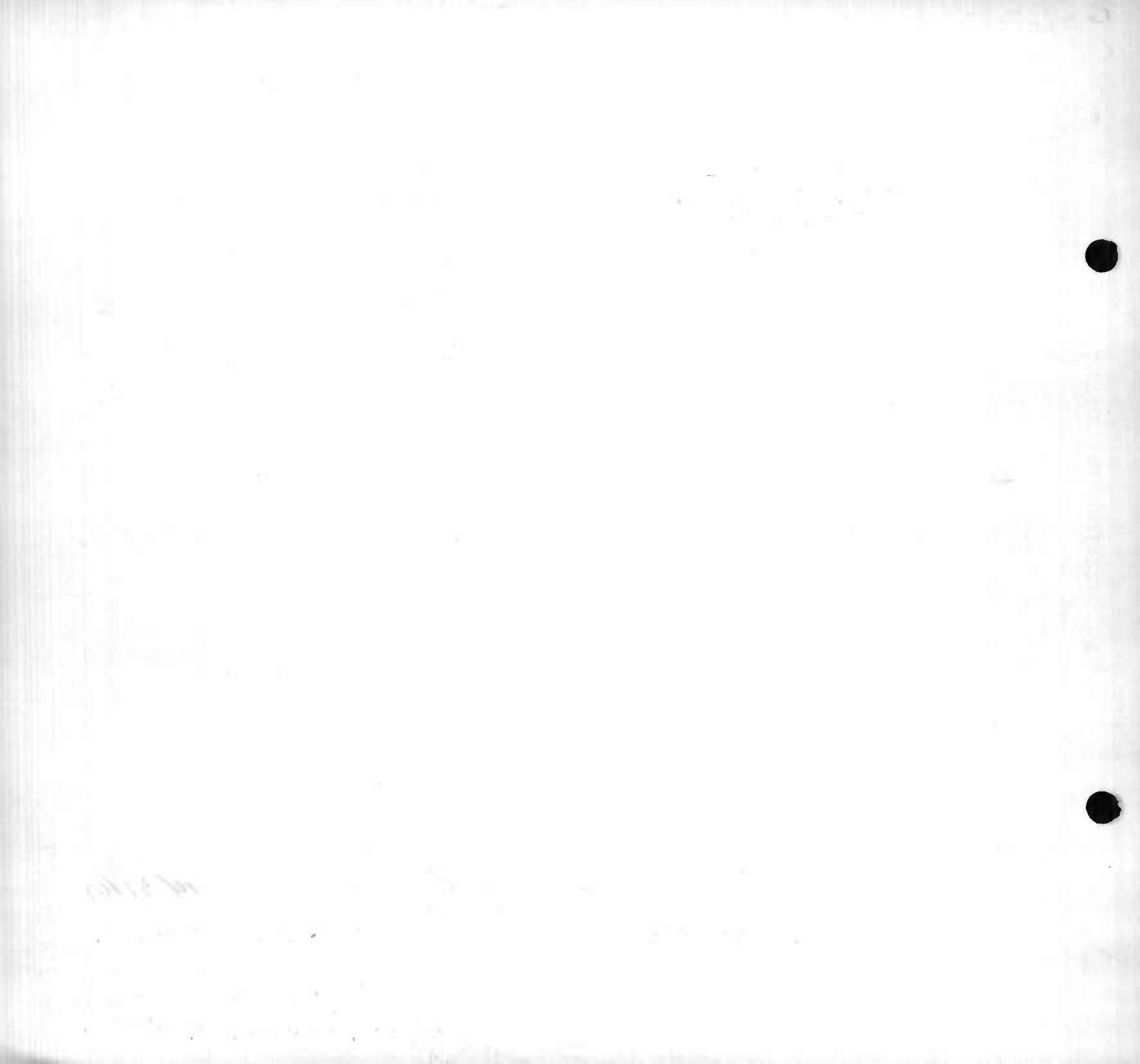
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10287 | |
|---|---|--|---|---|--|
| BIRTH NO. 67 10287 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) FLETCHER JACKSON | | 2. DATE AND HOUR OF DEATH
OCTOBER 27 FRI 1140 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
CHURCH HOME ? HOSPITAL | | A. STATE MARYLAND
B. COUNTY | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 21230 | | D. STREET ADDRESS (If rural, give location)
1757 William St. | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
NEVER MARRIED | 8. DATE OF BIRTH
12-30-1911 | 9. AGE (In years lost birthday)
55 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Boiler Maker | | 10B. KIND OF BUSINESS OR INDUSTRY
Shipyard | | 11. BIRTHPLACE (State or foreign country)
MARYLAND, Balto. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
DARIUS K JACKSON | | 14. MOTHER'S MAIDEN NAME
NELLIE BENNY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
212-07-0418 | | 17. INFORMANT
Mrs. Elsie Dunbar (Sister) 1138 Battery Ave 21230 | |
| 18. 155.1 I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying; e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) METASTATIC CARCINOMA
DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) CARCINOMA OF GALL BLADDER
DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from October 14 19 67 to October 27 19 67 , that (I) (we) last saw the deceased alive on October 27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Corazon Z. Vergara | | | | 23B. DATE SIGNED
October 27 '67 | |
| 23C. PHYSICIAN'S NAME (Type)
CORAZON Z. VERGARA | | | | 23D. ADDRESS
CHURCH HOME ? HOSP. 100 N. BROADWAY | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
Oct 31 1967 | | 24C. NAME OF CEMETERY OR CREMATORY
Cedarvale Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore & Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | | |
| 25B. NAME OF REGISTRAR
R. E. Taylor | | 25C. FUNERAL DIRECTOR
CURTIS E. EVANS 1400 S. CHARLES ST Baltimore | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 67 10288 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10288 | |
|---|-------------------------|---|---|---|--|---|-----------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) CAROLINE E. FRITZ | | | | 2. DATE AND HOUR OF DEATH
October 27, 1967 Fri 3:00 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
House in the Pines-Belvedere
2525 W. Belvedere Ave.
Baltimore, Maryland | | | | A. STATE Maryland
B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
15 E. PULLEY ST. | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never married | 8. DATE OF BIRTH
MARCH 28, 1889 | 9. AGE (In years last birthday)
78 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeper | | 10B. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MD | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Adam George Fritz | | | | 14. MOTHER'S MAIDEN NAME
KATHERINE Seigle | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
220-48-1034 | | 17. INFORMANT
MRS. JULIA A. FRITZ | |
| 18. 443X1 | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) PNEUMONIA | | 3 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Cerebral embolism | | 370 | |
| | | | | (C) Hypertension, arteriosclerosis | | 1.5 yr | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 15 1967 to Oct 27 1967 , that (I) (we) last saw the deceased alive on Oct 27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Lester Kolman M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Lester Kolman | | | | 23D. ADDRESS
M.D. 3700 Park Heights Ave. Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
May 30 1967 | | 24C. NAME OF CEMETERY, or CREMATORY
Cedar Hill Cem | | 24D. LOCATION (City, town, or county) (State)
BROOKLYN, N.Y. CONG | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
R. E. Taylor | | 25C. FUNERAL DIRECTOR
Curtis E. Evans | | ADDRESS
Charles St. Baltimore, Md. 21230 | |

CURTIS E. EVANS

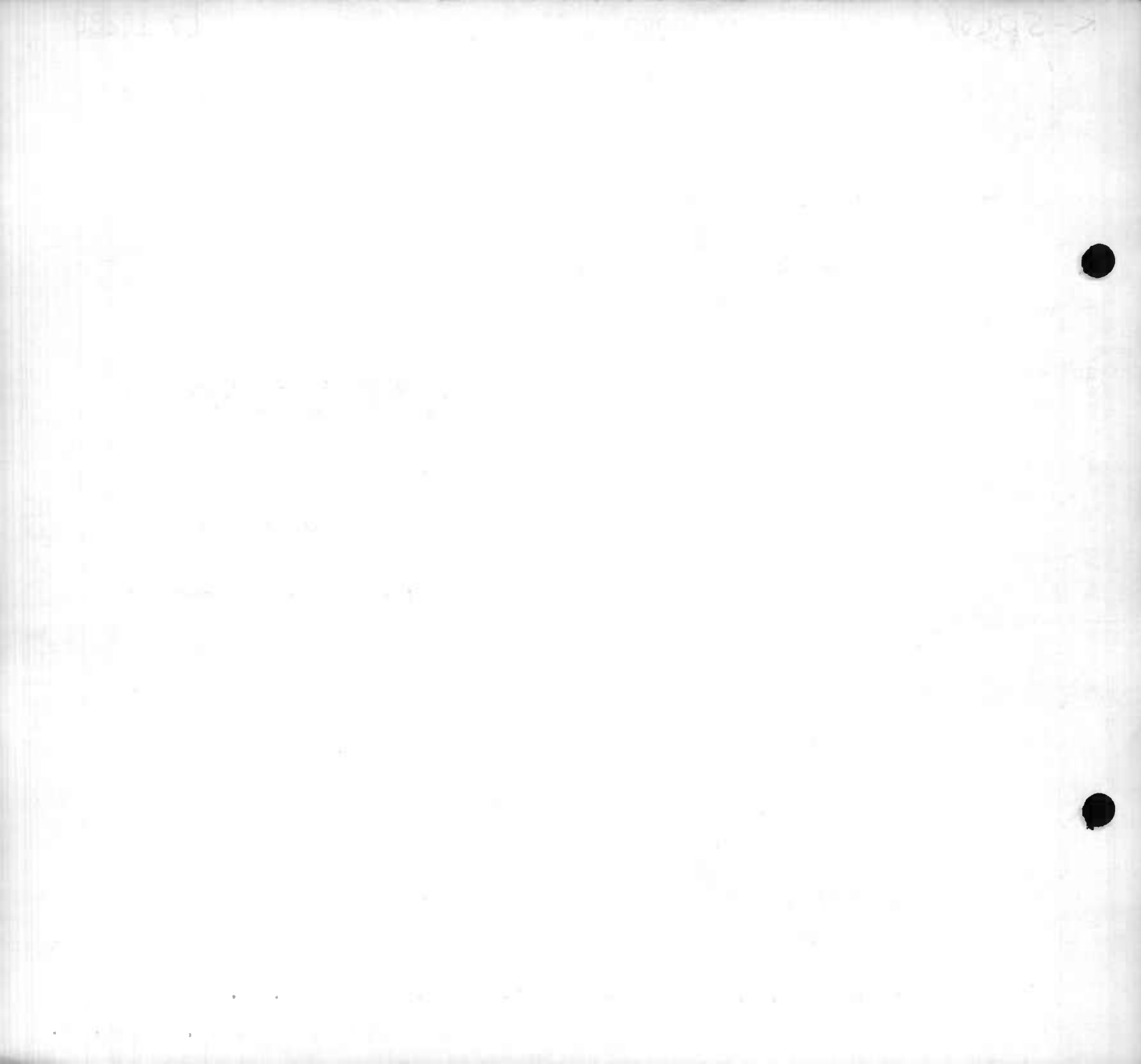


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10289 | |
|---|--------------------------------|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 10289 67 10289 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. 99736
1. NAME OF DECEASED
(Type or Print) MR. JOSEPH G. KUHN | | | 2. DATE AND HOUR OF DEATH
OCTOBER 27 1967 8:40 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BON SECOURS HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE Co.
53-00
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)
640 ALDERSHOT ROAD | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
7/4/93 | 9. AGE (In years lost birthday)
74 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
GILBERT KUHN | | | 14. MOTHER'S MAIDEN NAME
ANNA LEIGHT | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
Mrs. Joseph G. Kuhn
640 ALDERSHOT RD. | | |
| 18. 260 X I
CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 1 1967 to Oct. 27 1967, that (I) (we) last saw the deceased alive on Oct. 27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Nam Dooh Yang M.D. | | | | 23B. DATE SIGNED
Oct. 27, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
NAM DOOH YANG M.D. | | | | 23D. ADDRESS
Bon Secours Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/31/67 | 24C. NAME of CEMETERY or CREMATORY
New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
Oct 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
Witzke | |
| | | | | ADDRESS
4101 Edmondson Ave. Balto. Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10290 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10290 | |
|--|---------------------|--|---|---|---|
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | M. | |
| 1. NAME OF DECEASED
(Type or Print) MARIE ROHNACHER | | | 2. DATE AND HOUR OF DEATH
10-28-67 3:40 PM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
NO. CHARLES GEN. HOSP.
49 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY Balto. Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location)
1242 BIRCH AVE. | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
11-10-94 | 9. AGE (In years last birthday)
73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
Housewife | | 11. BIRTHPLACE (State or foreign country)
Germany | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Stephen Kielczynski | | 14. MOTHER'S MAIDEN NAME
Marianna Bednarek | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
216-03-0988 | | 17. INFORMANT ADDRESS
MRS. Wayne Schandlmeier
4 Glenwood Ave. - 21228 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) TERMINAL CA
DUE TO
(B) DUE TO
(C) DUE TO | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-28-67 19 to 10-28-67 19, that (I) (we) last saw the deceased alive on 10-28-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
[Signature] | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10-28-67 |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS
M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-1-67 | | 24C. NAME OF CEMETERY or CREMATORY
Lorraine Park | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert C. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Walter F. W. - 4101 Edmondson Dr | | | |

73 25-01

21-01-01

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HAYWOOD

REDDIN

2. DATE AND HOUR PRONOUNCED DEAD

October 23, 1967

4:44 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

821 W. Lexington St. (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Washington, D.C.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2205 Champlain St., N.W.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

W

8. DATE OF BIRTH

1897

9. AGE (in years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Simon Redden

14. MOTHER'S MAIDEN NAME

Julia Ann

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Clyde Redden 821 W Lexington St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic Cardiovascular Disease
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/24/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/27/67

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

OCT 30 1967

24B. NAME OF REGISTRAR

R. E. Fisher, M.D.

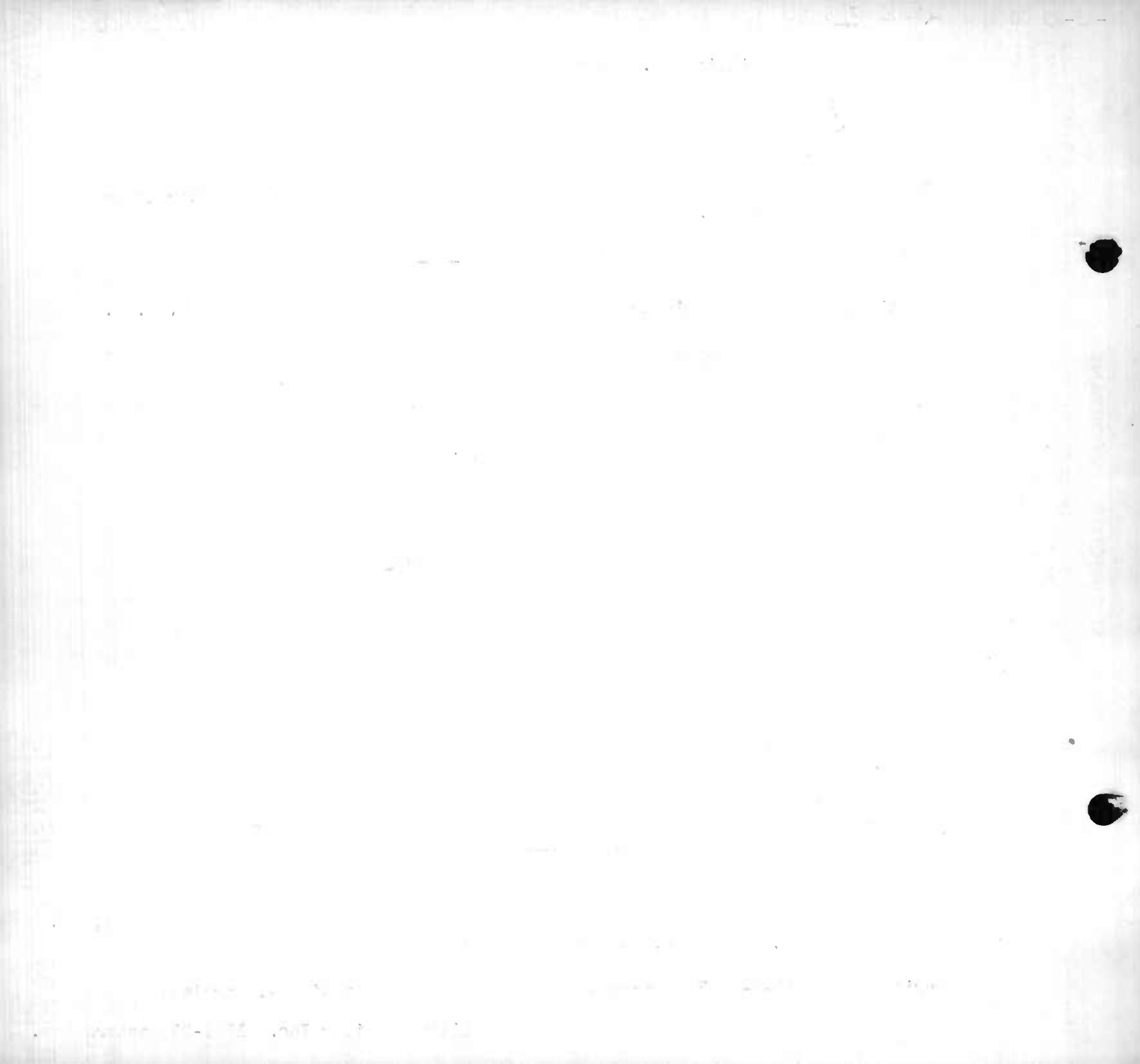
24C. FUNERAL DIRECTOR

Charles A. Rice 66 W Bond St

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-------------------------|---|--|--|--|--|--|
| K-620 | | 67 10292 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10292 | |
| BIRTH NO. | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Kresse, William</i> | | | | 2. DATE AND HOUR OF DEATH
<i>10/29/67 6²⁰ P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>31</i> BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MD. # 21224 | | | | A. STATE
MARYLAND
8. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give section)
3213 Foster Avenue
BALTIMORE CITY HOSPITALS | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
3-16-93 | 9. AGE (In years lost birthday)
74 | If Under 1 Yr. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
Engineer | | 11. BIRTHPLACE (State or foreign country)
GERMANY | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
MAX KRESSE | | | | 14. MOTHER'S MAIDEN NAME
MARIE BARTH | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
21224, MARYLAND ADDRESS
RECORDS: BCM 4940 EASTERN AVENUE, BALTIMORE | | | |
| 18. <i>743X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
<i>Cerebrovascular Accident</i>
(A) DUE TO
(B) DUE TO
(C) ACVD
INTERVAL BETWEEN ONSET AND DEATH
<i>unknown</i>
unknown | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (H) (this hospital) attended the deceased from <i>April 13 1966</i> to <i>10/29 1967</i> , that (I) (we) last saw the deceased alive on <i>10-29 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Raymond J. LaSure</i> M.D. | | | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
DR. RAYMOND J. LA SURE M.D. | | | | | | 23D. ADDRESS
BALTIMORE 21224, MD.
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-1-1967 | | 24C. NAME OF CEMETERY or CREMATORY
Parkwood | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR
Lilly & Zeiler Inc. | | ADDRESS
1901-07 Eastern Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------------------|--|--|--|--|--|--|
| BIRTH NO. W 425 | | 67 10293 | | BALTIMORE CITY HEALTH DEPT | | Registered No. 67 10293 | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Wilson, Morris | | | | 2. DATE AND HOUR OF DEATH
10/25/67 - 3⁴⁵ A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MD. B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
49 North Charles Gen Hosp
2724 N Charles St | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 6-02 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
431 N. Montford Ave 21224 | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
7/26/99 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Seaman | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Wash. State | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | 13. FATHER'S NAME
unknown | | | |
| 14. MOTHER'S MAIDEN NAME
unknown | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
556-16-9905 | | | | 17. INFORMANT
Chart | | | |
| 18. 692.4 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Bronchopneumonia, R
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Recent Abscess R hip | | | | INTERVAL BETWEEN ONSET AND DEATH
Recent | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/20 19 67 to 10/25 19 67 , that (I) (we) last saw the deceased alive on 10/25 19 67 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
GERMAN DE LA TORRE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/25/67 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. J. Blum | | | | 23D. ADDRESS
M.D. 1115 N. Calvert St #2 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-28-67 | | 24C. NAME OF CEMETERY or CREMATORY
LAKEVIEW MEMORIAL PK | | 24D. LOCATION (City, town, or county) (State)
BAKTO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
Stanley Miller - 2334 Jefferson St. | | ADDRESS | |

45-78-01

ME

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-------------------------------|---|---|
| BIRTH NO. 67 10294 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10294 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) BESSIE MARDERS (SUFCZYNSKI) | | 2. DATE AND HOUR OF DEATH
10/25/67 11:50 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY | | C. CITY OR TOWN (If outside city limits, with RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | D. STREET ADDRESS (If rural, give location)
4940 EASTERN AVENUE | | 2122 4 | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
DIVORCED | 8. DATE OF BIRTH
8-14-1908 | 9. AGE (In years lost birthday)
59 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FACTORY WORKER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
THOMAS FRANK MARDERS | | 14. MOTHER'S MAIDEN NAME
CARRIE PITTS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-01-6741 | | 17. INFORMANT
RECORDS: BCH 4940 EASTERN AVENUE BALTIMORE 21224 | |
| 18. 331 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Multiple CVA's
DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
1 year. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/27 1966 to 10/25 1967, that (I) (we) last saw the deceased alive on 10/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Jack Brandes | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/25/67 | |
| 23C. PHYSICIAN'S NAME (Type)
JACK BRANDES | | 23D. ADDRESS
M.D. 4940 EASTERN AVENUE BALTIMORE MARYLAND | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-27-67 | | 24C. NAME of CEMETERY or CREMATORY
MEADOW RIDGE CEM. | |
| 24D. LOCATION (City, town, or county) (State)
BALTO., MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farkner | | 25C. FUNERAL DIRECTOR
Hartley Hill - 2334 Jefferson St | |

8371-118

Virginia

(Cleric 1732)

— Ferns, Maryland

—

Nov. 1902

(Cleric 1732)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------------------|--|-------------------------------------|---|-------------------------------|--|--|
| BIRTH NO. <u>W-324</u> | | 67 10295 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>67 10295</u> | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) <u>AUGUSTA MARY WEITZEL</u> | | | |
| 2. DATE AND HOUR OF DEATH
<u>10-26-67</u> <u>7-A</u> M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>BALTIMORE</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>2416 E. FAYETTE ST.</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> <u>6-02</u> | | | |
| D. STREET ADDRESS (If rural, give location)
<u>2416 E. FAYETTE ST.</u> | | | | | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>3-3-1893</u> | 9. AGE (In years lost birthday)
<u>74</u> | If Under 1 Yr.
Months Days | If Under 24 Hrs.
Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>HOME</u> | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>SAMUEL DAVIDSON</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>LOUISE MEDGA</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>01754 2053</u> | | 17. INFORMANT ADDRESS
<u>Mr. Alvin L. Given - 5532 Ashbourne Rd.</u> | | | |
| 18. <u>443 X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <u>Coronary Heart Failure</u>
DUE TO
(B) <u>Ch. Hypertension</u>
DUE TO
(C) <u>" Arteriosclerosis "</u> | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT, WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 2</u> 19 <u>67</u> to <u>Oct-26</u> 19 <u>67</u> , that (I) (was) last saw the deceased alive on <u>Oct. 25</u> 19 <u>67</u> and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Wm. G. Geyer</u> M.D. | | | | 23B. DATE SIGNED
<u>Oct-30-67</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
<u>156 N. Melton Ave</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>10-30-67</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>BALTO. NATIONAL CEM.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>BALTO., Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 30 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>Stanley Miller - 2334 Jefferson St.</u> | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10296 | |
|--|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. H-400 | | 67 10296 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) HALL, Edmond McKinley, Jr. | | 2. DATE AND HOUR OF DEATH
October 28, 1967 10:25 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
27 Veterans Administration Hospital
3900 Loch Raven Blvd.
Baltimore, Maryland 21218 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 26-03 | | | |
| | | D. STREET ADDRESS (If rural, give location)
3550 Dudley Avenue | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
3/28/26 | 9. AGE (In years lost birthday)
41 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Fire Man | | 10B. KIND OF BUSINESS OR INDUSTRY
Fire Dept UNemployed | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
M. Edmond Hall Sr. | | | |
| 14. MOTHER'S MAIDEN NAME
Mary Crowe | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 6/27/44 to 6/27/46 | | | |
| 16. SOCIAL SECURITY NO.
214-20-6200 | | 17. INFORMANT
Records Veterans Administration Hospital, Balto., Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
146X I Carcinomatosis
Carcinoma of nasopharynx | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that 10 (this hospital) attended the deceased from September 1, 19 67 to October 28, 19 67 , that we last saw the deceased alive on October 28, 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. we (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Victor V.J. Borges</i>
Victor V.J. Borges | | | | 23B. DATE SIGNED
10-29-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Victor V.J. Borges | | 23D. ADDRESS
3900 Loch Raven Blvd. Balto. Md. 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
11-2-67 | | 24C. NAME OF CEMETERY or CREMATORY
BALTO. NATIONAL Cem. | |
| 24D. LOCATION (City, town, or county) (State)
BALTO., MD. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
John A. Miller | | | |
| 25D. ADDRESS
2332-34 Jefferson St. E.S. | | | | | |

• • • •

4

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **LEROY WILLIAM A BLACK** 2. DATE AND HOUR PRONOUNCED DEAD **October 27, 1967 1:58 p.m.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY **6-03**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
38/99 University Hospital D.O.A.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
209 N. Patterson Pk.

5. SEX **Male** 6. RACE **White**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
CHILD

8. DATE OF BIRTH **1-8-1956** 9. AGE (In years (last birthday)) **11** If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SCHOOL

10B. KIND OF BUSINESS OR INDUSTRY
-

11. BIRTHPLACE (State or foreign country)
MARYLAND

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME
ABNER LEROY BLACK

14. MOTHER'S MAIDEN NAME
ELIZABETH LOUISE BIRD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.
-

17. INFORMANT ADDRESS
Mr. Abner L. Black - 209 N. Patterson Pk.

18. **E82471** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) **Multiple traumatic injuries**
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION **0** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **No** 20A. AUTOPSY? (Yes or No) **No** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Howard South of Redwood Sts. 4-01

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)
10 27 67 1:41

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?
Hopped a ride on side of bus, fell, then

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ over him

ACTUAL SIGNATURE **Edward F. Wilson** EXAMINER'S NAME (Type) **Edward F. Wilson, M.D.**

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **October 27, 1967**

23A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL

23B. DATE
11-1-67

23C. NAME OF CEMETERY or CREMATORY
BALTO. NATIONAL Cem.

23D. LOCATION (City, town, or county) (State)
BALTO., Md.

24A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967

24B. NAME OF REGISTRAR
Robert E. Jankowski

24C. FUNERAL DIRECTOR ADDRESS
Harley Miller - 2334 Jefferson St.

1-8-1924

Marshall

Elizabeth Louise Gros

Mr. Charles E. Gros - 200 N. Tenth

Chico

Seneca

James Lewis Black

No

PAID

BRIDGE 11-1-03 BRIDGE ROAD CO. BRIDGE, MO.

Charles E. Gros - 200 N. Tenth

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 67 10298 | | CERTIFICATE OF DEATH | | Registered No. 67 10298 | |
|---|--|--|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) FRANCIS H. GAINES | | | | 2. DATE AND HOUR OF DEATH
Oct 24, 1967 | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
09746 PARK AVE. | | | | A. STATE
Maryland | | B. COUNTY
14-01 | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN
Baltimore | | D. STREET ADDRESS
1746 Park Ave | | | |
| 5. SEX
male | | 6. RACE
Negro | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | | 8. DATE OF BIRTH
7/1/1922 | | 9. AGE (In years last birthday)
45 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY
Railroad | | 11. BIRTHPLACE (State or foreign country)
Balto. Md | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME
Robert P. Gaines | | | | 14. MOTHER'S MAIDEN NAME
Nettie Swales | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes WWII | | | | 16. SOCIAL SECURITY NO.
215-16-2629 | | 17. INFORMANT
Mary Gaines | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Chronic Myocarditis | | | | CAUSE OF DEATH
(A) DUE TO
UNKNOWN CAUSE | | INTERVAL BETWEEN ONSET AND DEATH
18-24 mos | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | | | |
| (C) DUE TO | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/6/67 to 9/29/67 that (I) (we) last saw the deceased alive on 9/6/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Eljah Saunders | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/26/67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
ELJAH SAUNDERS | | | | 23D. ADDRESS
3414 Duvall Ave Baltimore, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
10/27/67 | | 24C. NAME OF CEMETERY or CREMATORY
Balto. Mt Cem | | 24D. LOCATION (City, town, or county) | | 24E. STATE
Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fadden | | 25C. FUNERAL DIRECTOR
Earl Gilmore | | | | | |
| | | | | ADDRESS
1827 W. North Ave | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 67-10299 | | Baltimore City Health Department | | CERTIFICATE OF DEATH | | Registered No. 67-10299 | |
|---|-------------------------|---|--|---|--|--|--|----------------------------------|--|
| 1. NAME OF DECEASED
(Type or Print) James Moore | | | | 2. DATE AND HOUR OF DEATH
10-26-67 | | 5:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
39 Provident Hospital, Inc.
1514 Division Street
Baltimore, Maryland 21217 | | | | A. STATE Maryland
B. COUNTY Baltimore | | | | | |
| | | | | C. CITY OR TOWN (If outside city limits, give township)
9-07 Baltimore | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
1720 Abbottson Street | | | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
12-10-23 | 9. AGE (In years last birthday)
43 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
South Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
IRVIN MOORE | | | | 14. MOTHER'S MAIDEN NAME
MARIE ROSALEE | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW II | | 16. SOCIAL SECURITY NO.
082189192 | | 17. INFORMANT
Mrs. Marie Moore-Mother | | ADDRESS
SAME | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) DUE TO
AS H D with myocardial infarction
(B) DUE TO
Alcoholism
(C) Hyperglycemia | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from October 24, 1967 to October 26, 1967 , that (I) (we) last saw the deceased alive on October 26, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
C. Laredo | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10-27-67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
C. Laredo | | | | 23D. ADDRESS
1514 Division Street Balto., Maryland | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-31-67 | | 24C. NAME OF CEMETERY or CREMATORY
BALTO. NAT'L. Cem. | | 24D. LOCATION (City, town, or county) (State)
BALTO., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
KEESON FUNERAL HOME 1348 Calhoun St. | | | | | |

RECEIVED
BALTIMORE CITY HEALTH DEPT.
JAN 12 1911

TO THE
BALTIMORE CITY HEALTH DEPT.
JAN 12 1911

RECEIVED
BALTIMORE CITY HEALTH DEPT.
JAN 12 1911

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10300

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THELMA THOMPSON

MOORE

2. DATE AND HOUR PRONOUNCED DEAD

October 28, 1967

2:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2846 Parkwood Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4-13-1929

9. AGE (in years
last birthday)

38

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Nursing Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Arthur Banks Thompson

14. MOTHER'S MAIDEN NAME

CLARA Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

William Moore 2846 Parkwood.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH292.6 I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Sickle Cell Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/28/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

11-1-67

23C. NAME of CEMETERY or CREMATORY

Balto. Nat'l Cem

23D. LOCATION

(City, town, or county)

Baltimore

Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 30 1967

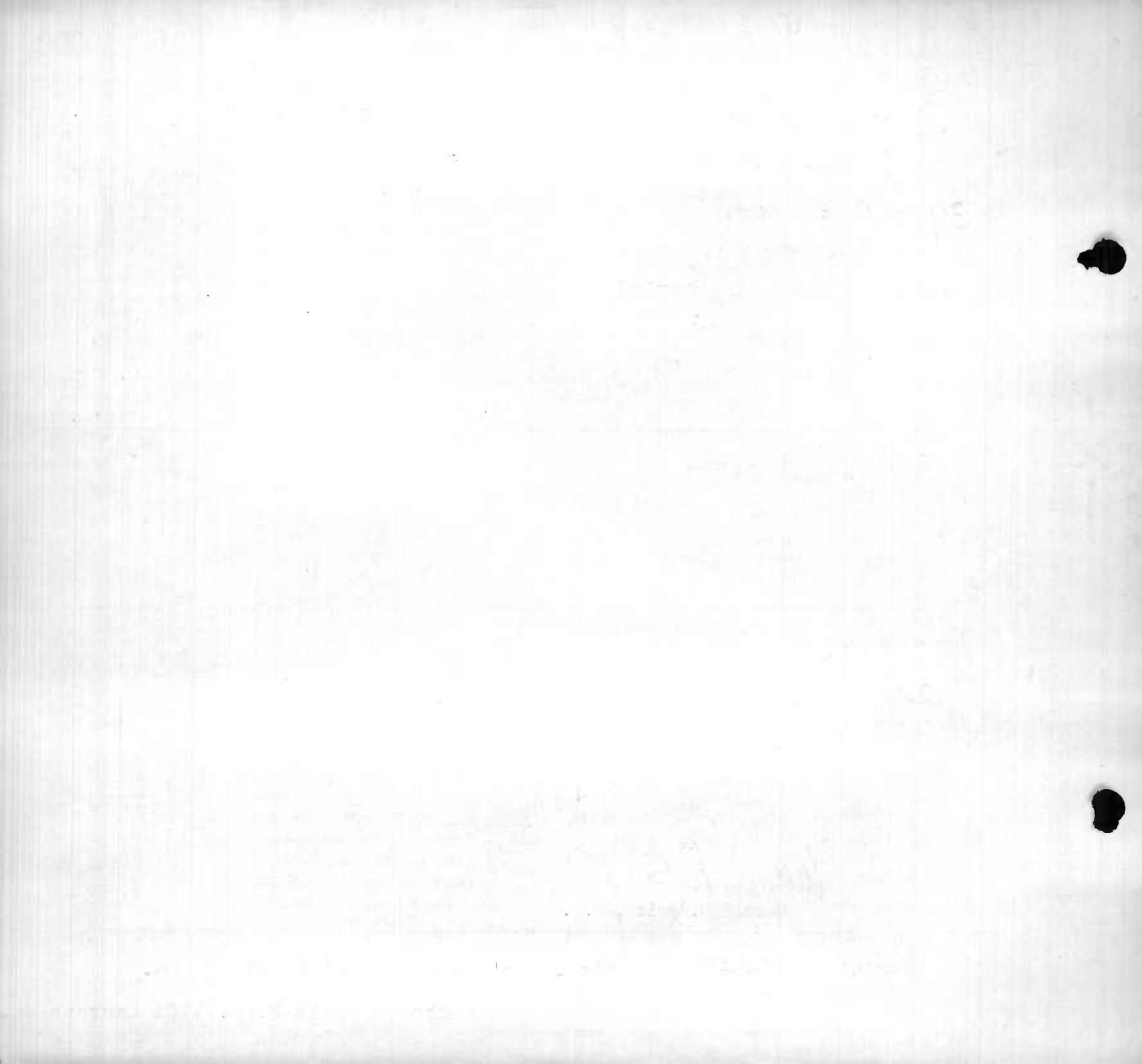
24B. NAME OF REGISTRAR

Robert E. Spitz

24C. FUNERAL DIRECTOR

ADDRESS

Morton & Dyett F. H. 1701 Laurens St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10301 | |
|---|---|---|---|---|--|
| BIRTH NO. 67 10301 | | CERTIFICATE OF DEATH | | M. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Edgard Moore (Edward) | | 2. DATE AND HOUR OF DEATH
6:25 AM - 10-27-67 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Baltimore
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
48 Maryland General Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | D. STREET ADDRESS (If rural, give location)
2504 Salem St 21-17 | | | |
| 5. SEX
Male | 6. RACE
N | 7. MARRIED NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
11-15-99 | 9. AGE (In years last birthday)
67 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore Texas | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Benjamin Moore | | 14. MOTHER'S MAIDEN NAME
UNK. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
217-03-2878A | | 17. INFORMANT
wife | |
| 18. 443 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CORONARY ARTERIOSCLEROSIS & MYOCARDIAL INFARCTION - DUE TO VASCULAR DISEASE
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(A) general arteriosclerosis and (B) coronary arteriosclerosis (C) myocardial infarction | | CAUSE OF DEATH
CORONARY ARTERIOSCLEROSIS & MYOCARDIAL INFARCTION - DUE TO VASCULAR DISEASE | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-25 1967 to 10-27 1967, that (I) (we) last saw the deceased alive on 10-27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Cyrus Makow | | | | 23B. DATE SIGNED
10-27-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Cyrus Makow | | | | 23D. ADDRESS
Maryland Gen Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-31-67 | | 24C. NAME OF CEMETERY or CREMATORY
MT Auburn | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
R. E. Fairman | |
| 25C. FUNERAL DIRECTOR
MORTON + Dett | | 25D. ADDRESS
1701 LAURENS | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------------|---|--|---|--|---|--|
| 50
BIRTH NO. | | 67 10302 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10302 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Harley Green</u> | | | | 2. DATE AND HOUR OF DEATH
<u>10/26/67 17 P M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Johns Hopkins Hospital</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore 53-00</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>117 Bal New Ave</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | | 8. DATE OF BIRTH
<u>11/13/1900</u> | | 9. AGE (In years lost birthday)
<u>66</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Isle Wright, Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Albert Green</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Rebecca Williams</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Unknown</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>Mrs. Marie Green 117 Main Street</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Pneumonia</u> | | | | CAUSE OF DEATH
(A) <u>Aspiration from</u>
(B) <u>tracheo-esophageal fistula</u>
(C) <u>Esophageal Ca</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>2 months</u> | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| 11
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>9/13/67</u> 19 <u>67</u> to <u>10/26/67</u> 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>10/26/67</u> 19 <u>67</u> and that (1) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Albert B. Einstein, Jr.</u> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>10/26/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Albert B. Einstein, Jr.</u> M.D. | | | | 23D. ADDRESS
<u>Johns Hopkins Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>10-30-67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Arbutus Mem. Park</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Arbutus, Md.</u> | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
<u>OCT 30 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Morton E. Dyett F.H.</u> | | ADDRESS
<u>1701 LAURENS</u> | |

19

1951

11/11/51

117 Baltimore Ave
Baltimore

11/11/51

Rebecca Williams

Johns Hopkins Hospital

M W Married 11/11/51

Albert Green

Unknown

Pneumonia
Aspiration from
tracheo-oesophageal fistula
Foster Hospital

Yes

10/26/51

11/3/51

10/26/51

Albert B. Feinstein, Jr.

Johns Hopkins Hospital

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ESSIE KING

2. DATE AND HOUR PRONOUNCED DEAD

October 27, 1967 9:30a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1628 Harford Ave.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Feb 12 1899

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

M. C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

Mary Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

James King 2403 N. Highland Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 27, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

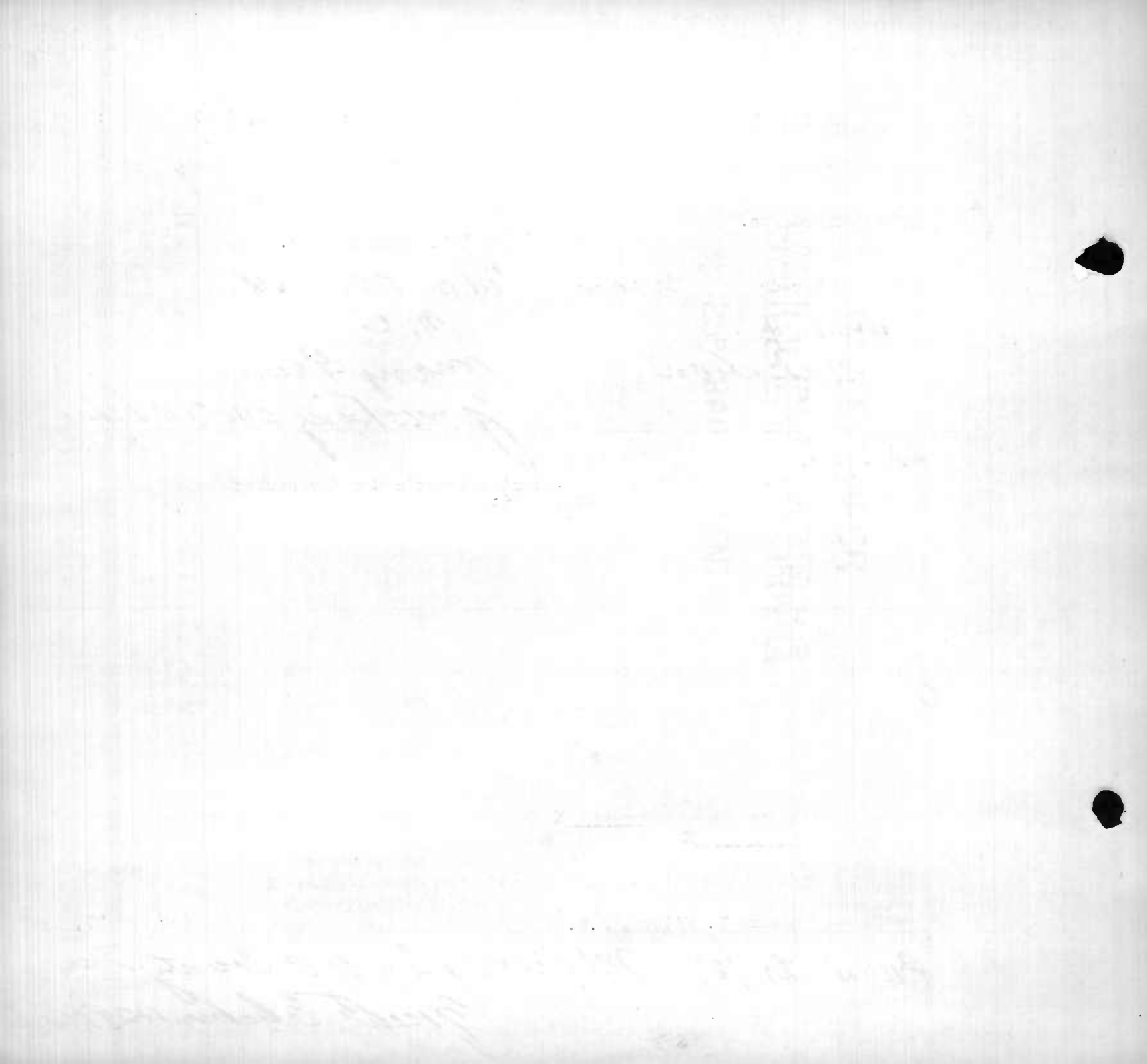
(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

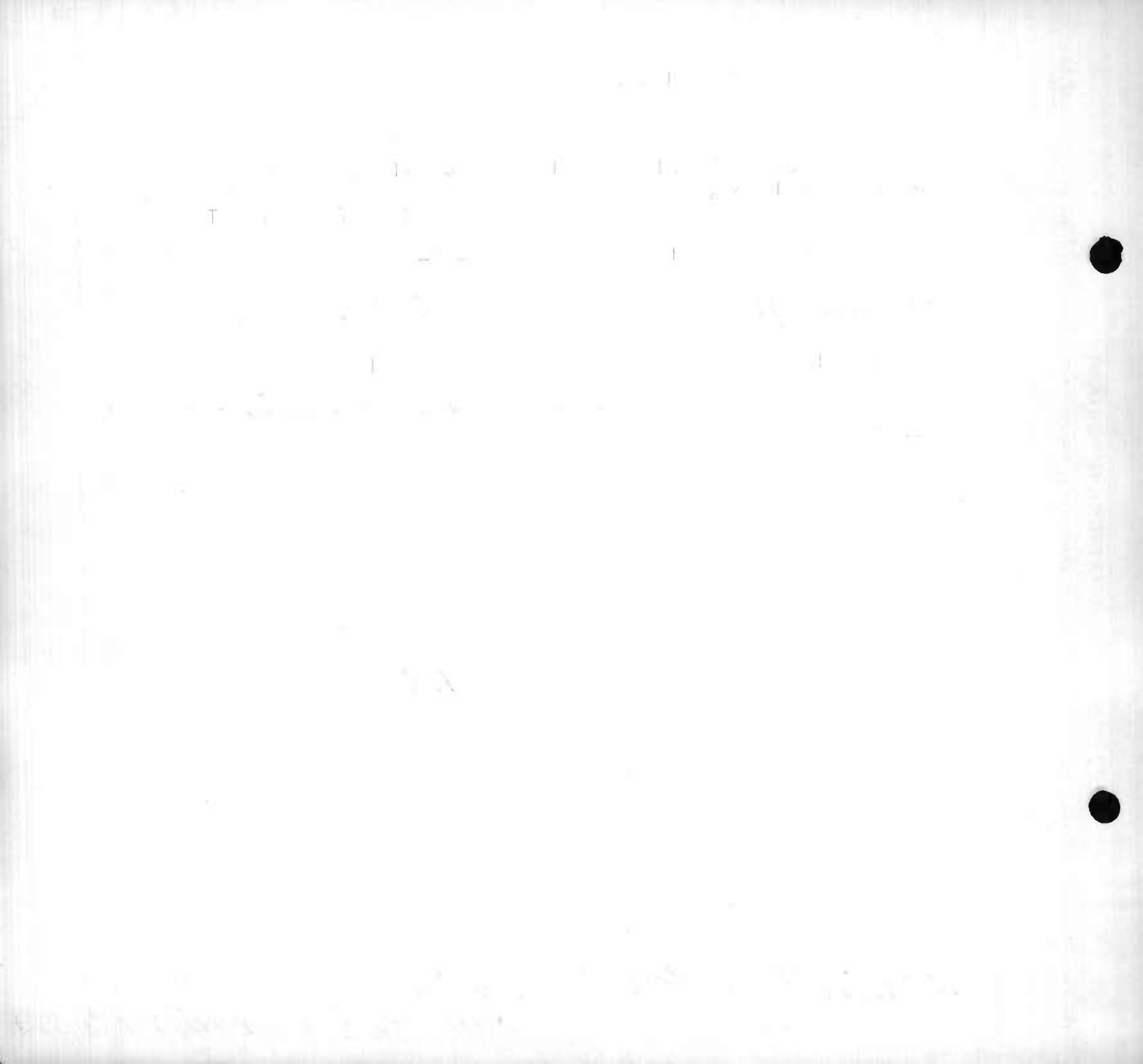
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 67 10304 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10304 | |
|--|-------------------------|---|---|--|----------------------------|--|-----------------------------|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) BEULAH HAMILTON | | | | 2. DATE AND HOUR OF DEATH
10/30/67 5:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
33 THE JOHNS HOPKINS HOSPITAL
BALTIMORE, MD 21205 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give town ship)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
1220 CHATMAN STREET | | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
12-29-91 | 9. AGE (In years last birthday)
75 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
S.C. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
WEST GRIMES | | | 14. MOTHER'S MAIDEN NAME
CARRIE | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
245-20-7403 | | 17. INFORMANT
John Hamilton | | ADDRESS
521 N. Patterson | |
| 18. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) ? CUA
DUE TO
(B) ASCUD
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II | | | | Chylous Ascites ? 2° to Post Neoplastic cirrhosis or Tumor | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/24 19 67 to 10/30 19 67 , that (I) (we) last saw the deceased alive on 10/30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Henry R. Black
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
10/30/67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
HENRY R. BLACK | | | | 23D. ADDRESS
Johns Hopkins Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/6/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem. | | 24D. LOCATION (City, town, or county) (State)
A.A. County Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairburn | | 25C. FUNERAL DIRECTOR
Milton E. Ellickson | | ADDRESS
129 N. Conlin St | |



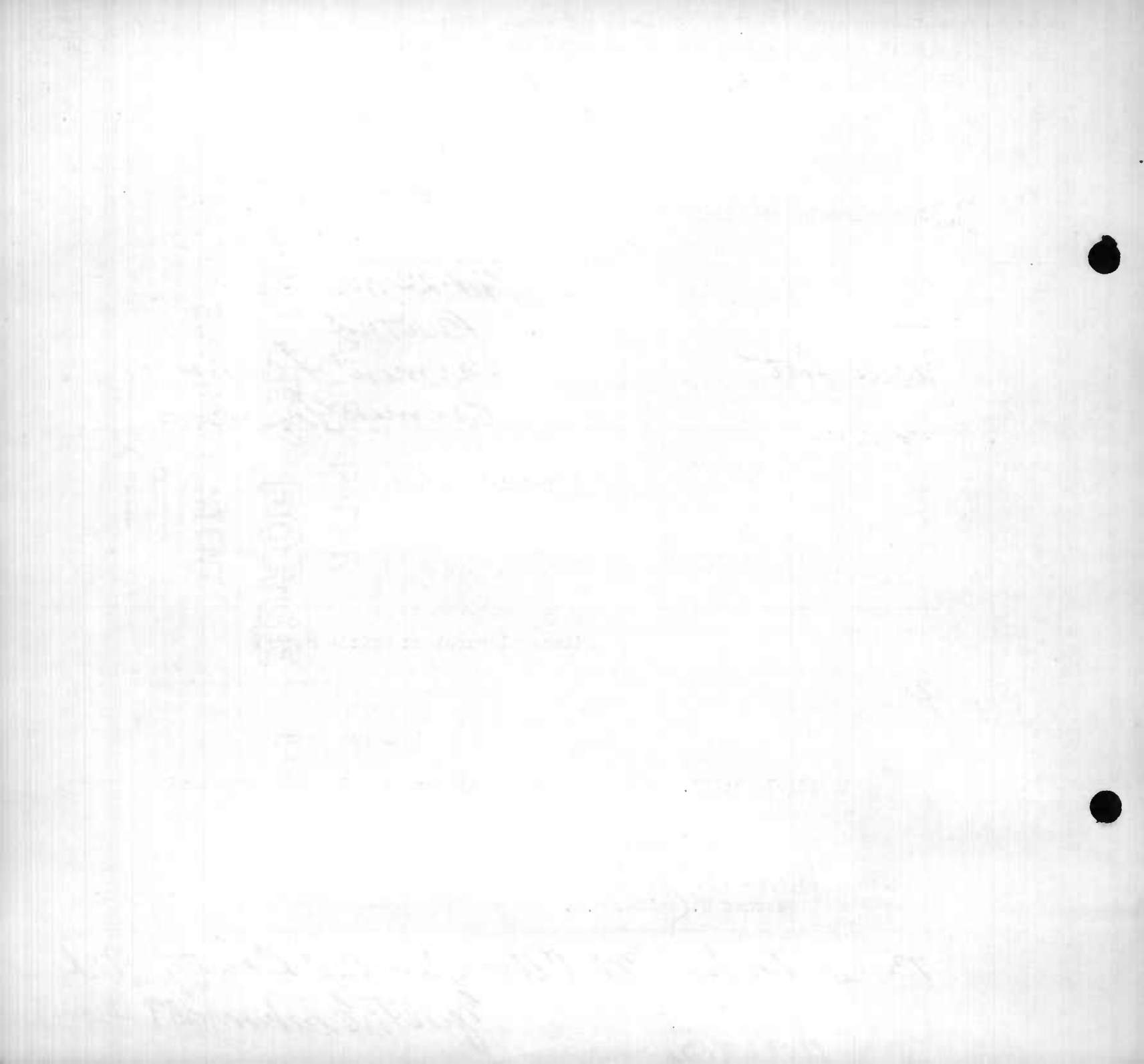
L-300

67 10305

BALTIMORE CITY HEALTH DEPARTMENT

67 10305

| | | | | | |
|---|------------------|--|--|--|--|
| BIRTH NO. 66-02562 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
DONALD LOTT | | | 2. DATE AND HOUR PRONOUNCED DEAD
October 28, 1967 1:40 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
33 Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1422 May Court | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH
Feb 22 1966 | 9. AGE (In years last birthday)
1 1/2 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore | |
| 13. FATHER'S NAME
Jessie Lott | | 14. MOTHER'S MAIDEN NAME
Carmen Freeman | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Carmen Freeman | |
| 18. CAUSE OF DEATH
E 902.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Multiple Injuries
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Bilateral Purulent Otitis Media | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
1422 May Court | |
| 21D. TIME OF INJURY (APPROX.)
10/28/67 9:10P. | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Supposedly fell from chair | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 10/28/67 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
Nov 1/67 | | 23C. NAME of CEMETERY or CREMATORY
Mt Calvary Cemetery Ad County Md | |
| 24A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 24B. NAME OF REGISTRAR
R. E. E. E. | | 24C. FUNERAL DIRECTOR ADDRESS
Frank T. Elickson 11297 Caroline St | |

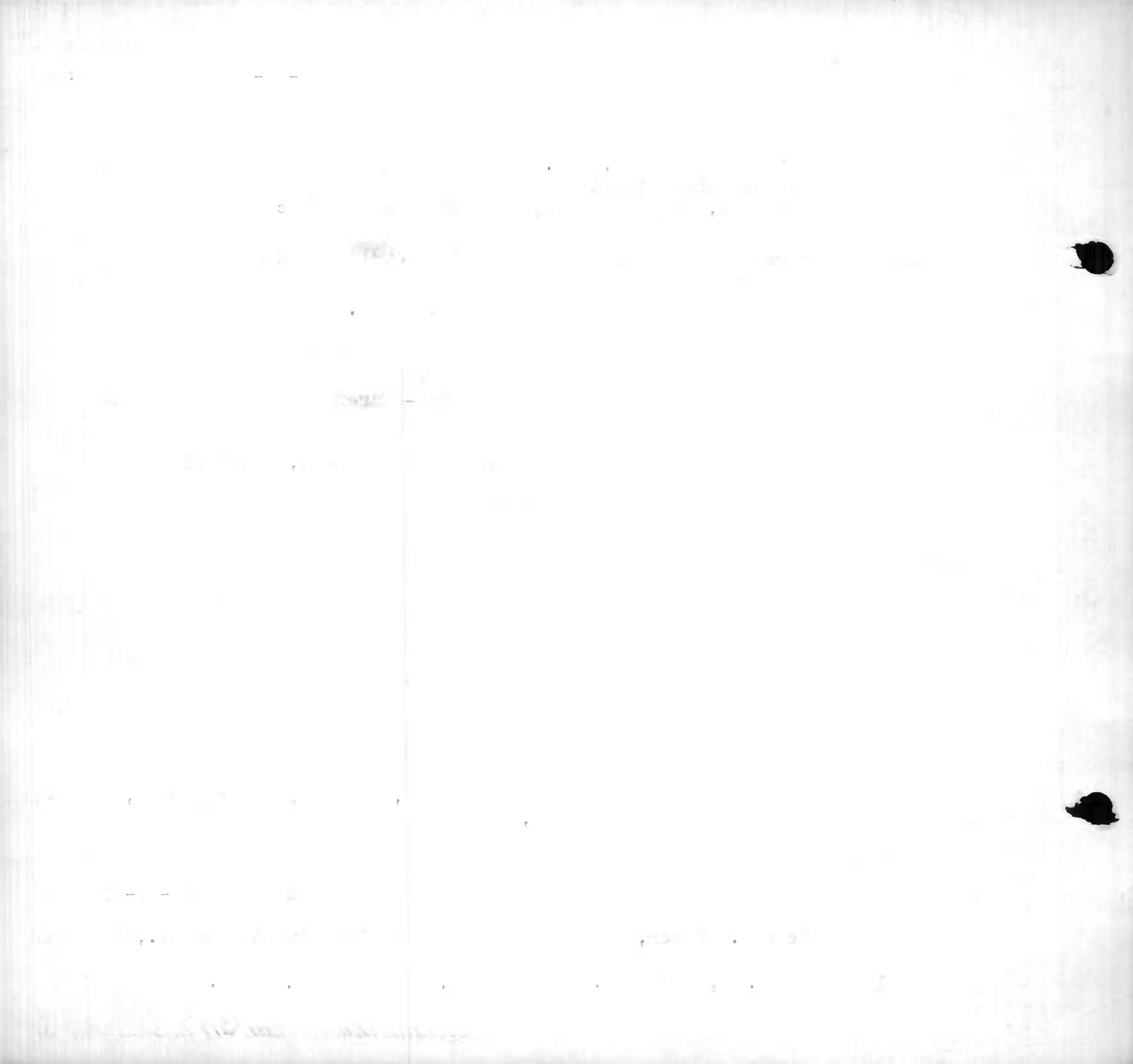


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10306 | |
|---|-------------------------|--|---|---|--|
| BIRTH NO. 67 10306 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) George Warren | | 2. DATE AND HOUR OF DEATH
EOR 10-27-67 2:42 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
39
Provident Hospital, Inc.
1514 Division Street
Baltimore, Maryland 21217 | | A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
905 Bennette Place | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
July 4, 1913 | 9. AGE (In years last birthday)
54 yrs | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Capron Va. | |
| 13. FATHER'S NAME
Emanuel Warren | | 14. MOTHER'S MAIDEN NAME
Daisey Parker | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mary Warren
ADDRESS
SAME | |
| 18. 163X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Possible Ca of lungs, terminal stage
DUE TO
(B)
DUE TO
(C)
INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from October 27, 19 67 to October 27, 19 67 , that (I) (we) last saw the deceased alive on October 27, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)
Jean C. Victor, | | | | 23B. DATE SIGNED
10-27-67
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Oct. 31, 1967 | | 24C. NAME of CEMETERY or CREMATORY
Mt. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fabe... | | 25C. FUNERAL DIRECTOR
Williams Funeral Home 319 N. Schomaker St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| BIRTH NO. W-236 | | 67 10307 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10307 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Carl L. Wagner, Sr. | | | |
| 2. DATE AND HOUR OF DEATH 10/28/67 | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE BALTIMORE B. COUNTY BALTIMORE | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 11, Maryland | | | |
| D. STREET ADDRESS (If rural, give location)
3752 Tadow Arms Ave | | | | E. PLACE OF DEATH (If not in hospital or institution, give street address or location)
Union Memorial Hospital | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH 9/23/96 | |
| 9. AGE (In years last birthday) 71 | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME Charles E. Wagner | | | | 14. MOTHER'S MAIDEN NAME Sidonia Schirmer | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WWII 2/2-09-2728 | | | | 16. SOCIAL SECURITY NO. 212-09-2728 | | | |
| 17. INFORMANT Mrs. Adelaide H. Wagner (Sister) | | | | ADDRESS BALTIMORE | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ASCVD | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.
Chronic Bronchitis & emphysema | | | | 20. CAUSE OF DEATH
(A) DUE TO ASCVD
(B) DUE TO Chronic Bronchitis & emphysema
(C) Chronic Renal Disease 20 to 30 yrs | | | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. | | | | 22. I certify that (1) (this hospital) attended the deceased from 10/23/67 to 10/28/67 , that (2) (we) last saw the deceased alive on 10/28/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE David A. Schwartz | | | | 23B. DATE SIGNED 10/28/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. DAVID A. SCHWARTZ | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10/31/67 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood | | 24D. LOCATION (City, town, or county) (State) Parkville, Balto. Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 30 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | 25D. ADDRESS 4905 York Rd. Balto., Md. | |

10/10

10/10

10/10 10/10 10/10

10/10 10/10 10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 10308 | |
|---|---|---|--|--|--|---|--|
| BIRTH NO. 67 10308 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) BERTA C. ROSE | | 2. DATE AND HOUR OF DEATH
10/27/67 10:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
42 SINAI HOSPT. | | (If not in hospital or institution, give street address or location) | | A. STATE
MARYLAND | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO. 27-48 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
5410 LOTHIAN RD. | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
9/11/1896 | 9. AGE (In years lost birthday)
71 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | 11. BIRTHPLACE (State or foreign country)
ARKANSAS | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
LACY | | | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-07-1416 | | 17. INFORMANT
MARTIN F. ROSE | | ADDRESS
Above | |
| 18. 204.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) ACUTE LEUKEMIA
DUE TO

(B) DUE TO

(C) | | INTERVAL BETWEEN ONSET AND DEATH
5 months | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/19/67 19 to 10/27/67 19, that (I) (we) last saw the deceased alive on 10/27/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Ronald Schachar M.D. | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
RONALD SCHACHAR M.D. | | | | 23D. ADDRESS
SINAI HOSPITAL OF BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Entombment | | 24B. DATE
10-30-67 | | 24C. NAME OF CEMETERY or CREMATORY
Moreland Memorial | | 24D. LOCATION (City, town, or county) (State)
Baltimore Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | ADDRESS
4905 York Rd. | |

21st Host

2410 Location 100

PHOTO

1000000

11/1/88

MARKED

Female Pigeon

Open House

Housewife

Lucy

Lucy

212-02-1112 11/1/88

100

Acute Arteritis

11/2/88

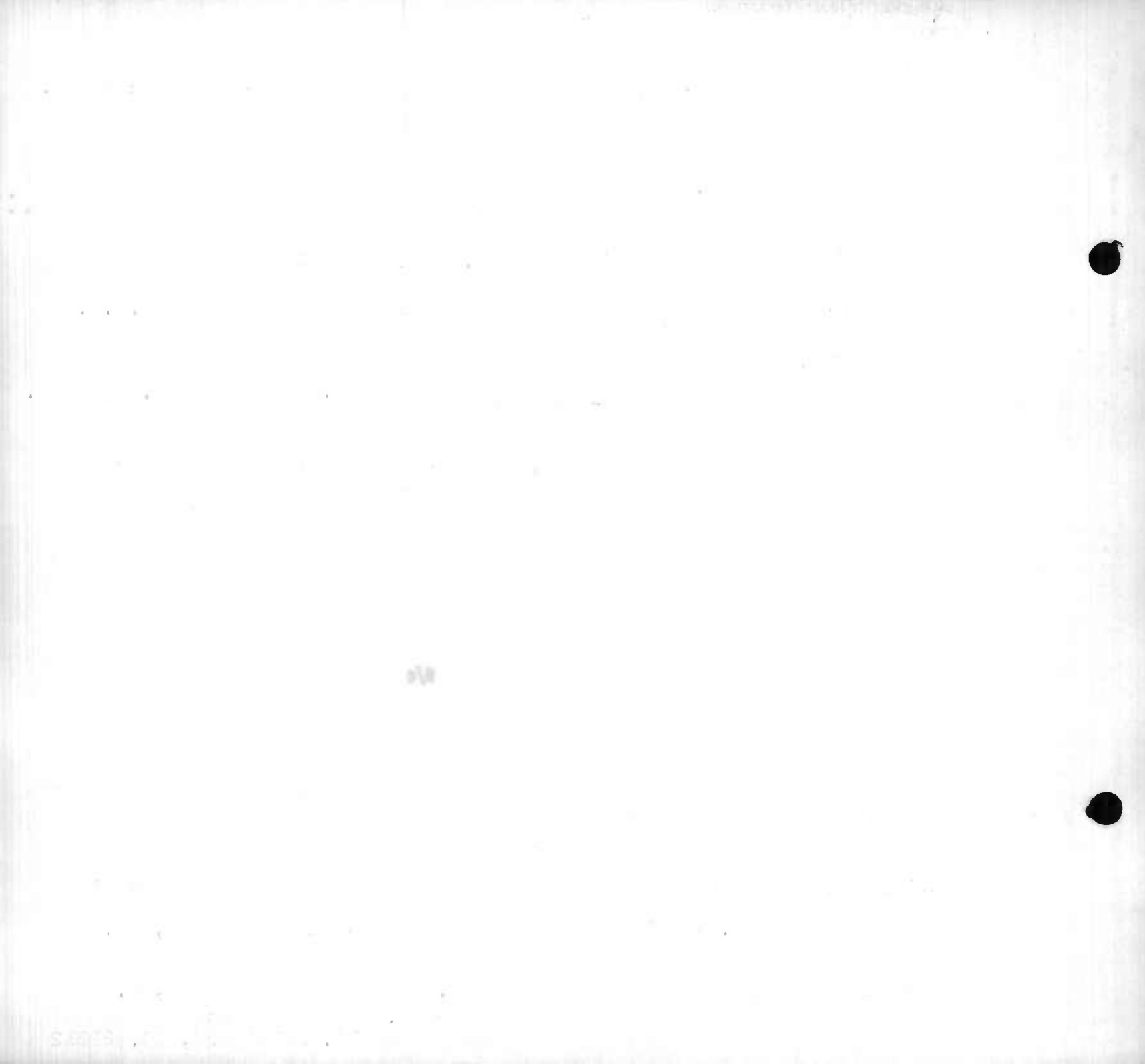
11/2/88

2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

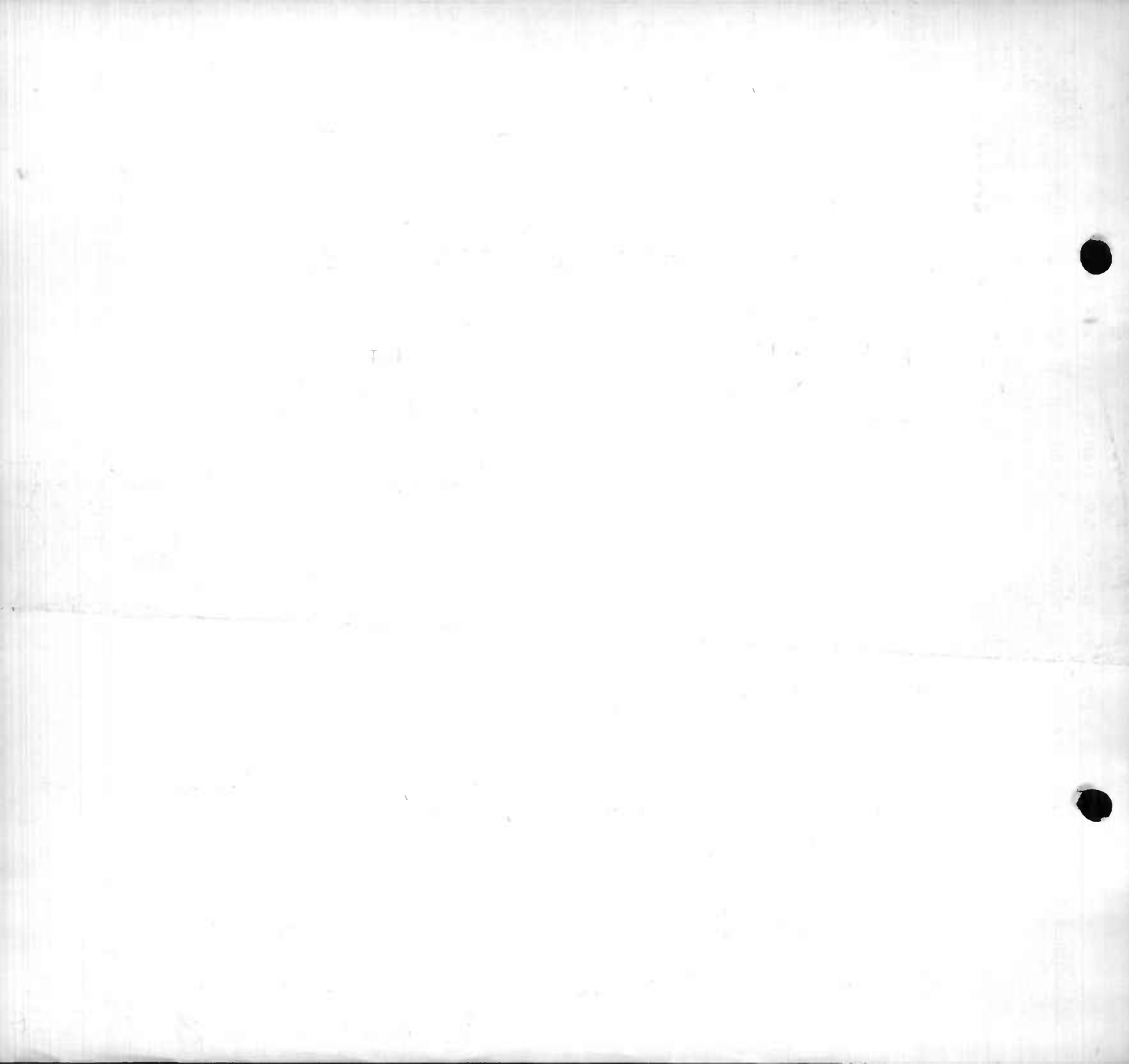
| | | | | | | | |
|--|----------------------|---|--|--|--|---|---|
| 7-140 | | 67 10309 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10309 | |
| BIRTH NO. 67 10309 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) Harriett A. Teeple | | | | 2. DATE AND HOUR OF DEATH
October 26, 1967 10:10 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
718 East 33rd. Street | | | | A. STATE Maryland
B. COUNTY Baltimore | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
718 East 33rd Street | | | |
| 5. SEX
Female | 6. RACE
W. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
10/31/ 1896 | 9. AGE (In years lost birthday)
70 | If Under 1 Yr.
Months Days | If Under 24 Hrs.
Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Owosso, Michigan | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Charles J. Miller | | | | 14. MOTHER'S MAIDEN NAME
Hermine Herzog | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-07-8231 | | 17. INFORMANT
Kenneth S. Teeple | | ADDRESS
718 E. 33rd St. | |
| 18. 443 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Hypertensive Arteriosclerosis (Cerebrovascular) | | | | CAUSE OF DEATH
Hypertensive Arteriosclerosis (Cerebrovascular) | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1955 to Oct 26 19 67 , that (I) (we) last saw the deceased alive on Sept 30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Thomas L. Worsley | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/28/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Thomas L. Worsley | | | | 23D. ADDRESS
6505 York Road Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/30/67 | | 24C. NAME OF CEMETERY or CREMATORY
Dulaney Valley Mem. Gardens | | 24D. LOCATION (City, town, or county) (State)
Timonium, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
Henry W. Jenkins & Sons Co | | ADDRESS
4905 York Rd. Baltimore, Md. 21212 | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|-----------------------------|--|--------------------------------------|
| BIRTH NO. 67 10310 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10310 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) BRAXTON, CARRIE E. | | 2. DATE AND HOUR OF DEATH
10/23/67 1:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland ---
B. COUNTY ---
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
433 E. 20th Street | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
5/01/04 | 9. AGE (In years birthday)
64 | 10. Under 1 Yr. Months Days
12-04 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 13. FATHER'S NAME
CHARLES ELLIS | | 14. MOTHER'S MAIDEN NAME
HARRIET | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Hospital Record | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
331X I
Right intracerebral hemorrhage
DUE TO | | CAUSE OF DEATH
(A) Right intracerebral hemorrhage
(B) DUE TO
(C) ESSENTIAL HYPERTENSION | | INTERVAL BETWEEN ONSET AND DEATH
3 wks. ? recurrence at time of death
10 years | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from October 2, 1967 to October 23, 1967, that (I) (we) last saw the deceased alive on October 23, 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
David J. Shaw | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/23/67 | |
| 23C. PHYSICIAN'S NAME (Type)
David J. Shaw | | 23D. ADDRESS
M.D. Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-28-67 | | 24C. NAME of CEMETERY or CREMATORY
Mt Auburn Cem Baltimore Md | |
| 24D. LOCATION
(City, town, or county) (State)
Baltimore Md | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
R. E. Taylor | |
| 25C. FUNERAL DIRECTOR
Rayner Sanders | | 25D. ADDRESS
2176 Preston St | | | |



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES C. WILKINS

2. DATE AND HOUR PRONOUNCED DEAD

October 26, 1967 10:40 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

00412 North Pine St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

412 Pine St.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1-14-1898 69

9. AGE (In years
last birthday)

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Wilkins Sr

14. MOTHER'S MAIDEN NAME

BETTIE LAYNE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Henrietta Brook 8437 Bentall St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK NOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 26, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10-31-67

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem

23D. LOCATION

Balto

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

OCT 30 1967

24B. NAME OF REGISTRAR

John E. Johnson

24C. FUNERAL DIRECTOR

Layner Sanders

ADDRESS

217 E. Preston St

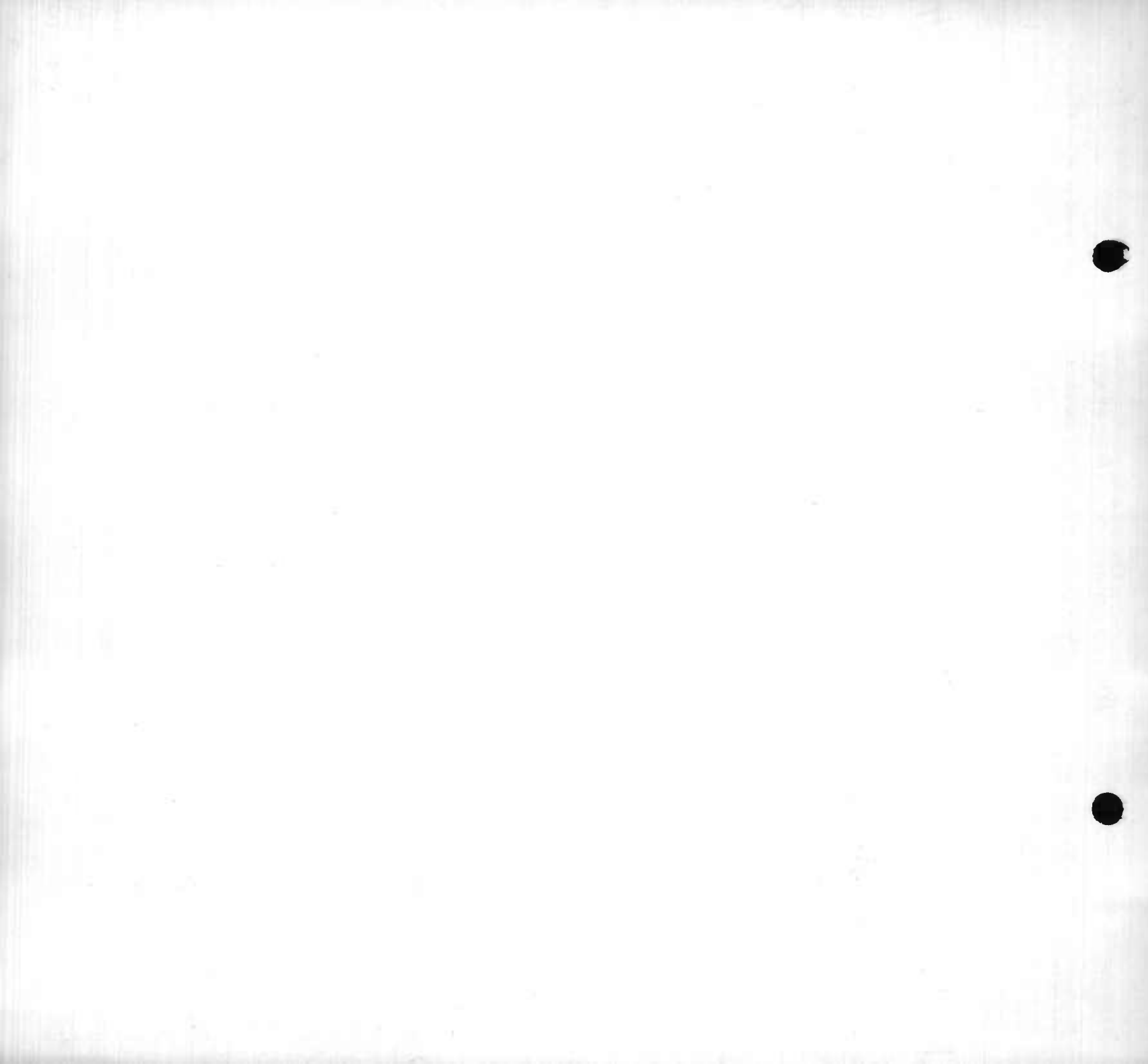


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|--|---|---|
| BIRTH NO.
67 10312 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10312 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>William T. Briscoe Jr.</i> | | 2. DATE AND HOUR OF DEATH
<i>26 Oct 1967 4:47 P. M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

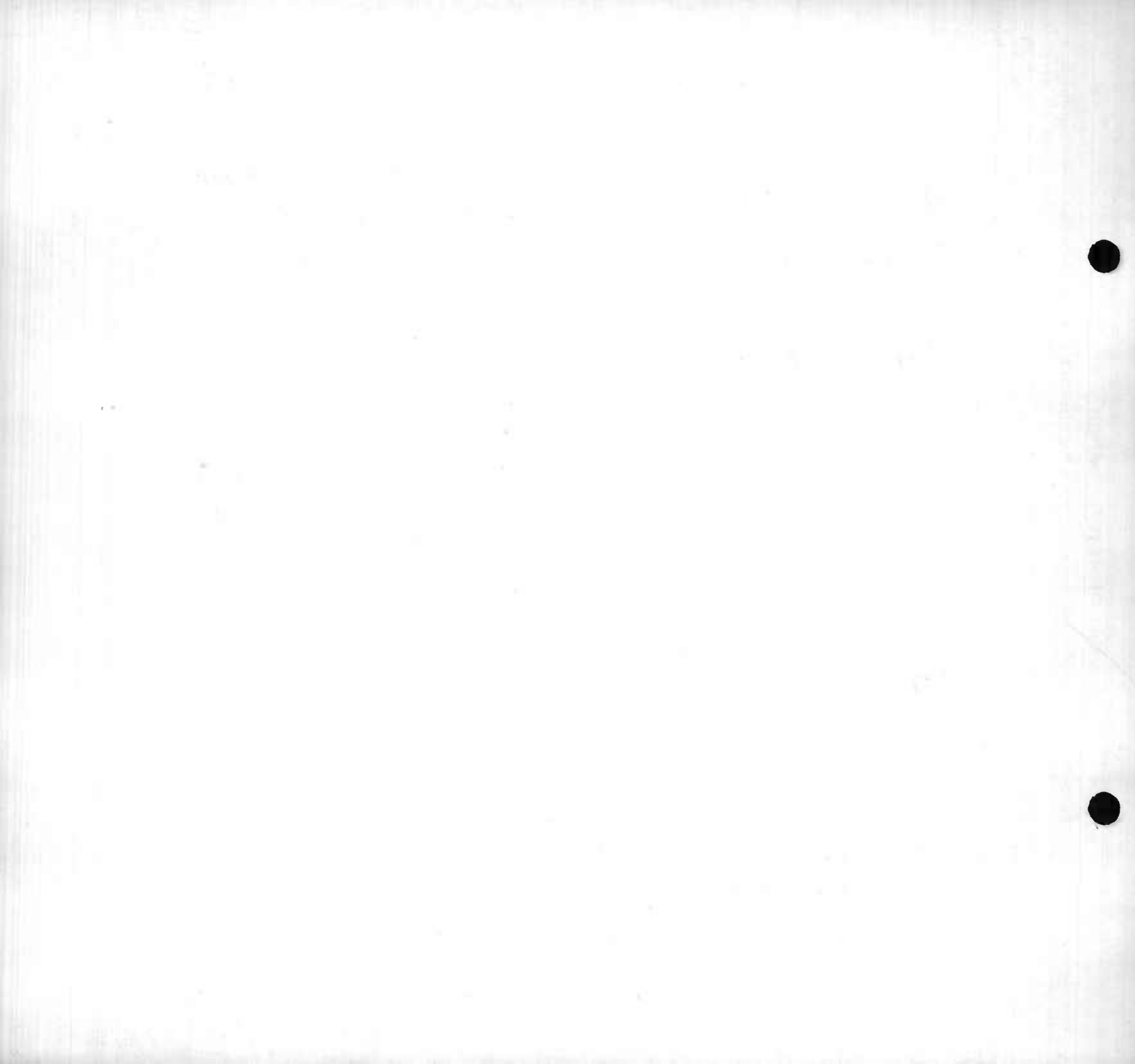
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>Univ. of Md. Hosp</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i>
B. COUNTY <i>Balto</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>14-02</i>
D. STREET ADDRESS (If rural, give location)
<i>509 Laurens St.</i> | | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>Negro</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Single</i> | 8. DATE OF BIRTH
<i>8 June 1940</i> | 9. AGE (In years, lost birthday)
<i>27</i> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
<i>William T. Briscoe</i> | | 14. MOTHER'S MAIDEN NAME
<i>Olive Damurg</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Joseph Briscoe</i> ADDRESS <i>3104 Walcott Ave</i> | |
| 18. <i>411 X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
<i>Cardiac Arrest</i> | | 19A. DATE OF OPERATION
<i>26 Oct 1967</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Aortic Insufficiency</i> | |
| 19C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>26 September 1967</i> to <i>26 October 1967</i> , that (I) (we) last saw the deceased alive on <i>26 Oct. 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Santos, Ch. D.</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>26 Oct 1967</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Delfin S. Santos, M.D.</i> | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>10/31/67</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Mt. Auburn</i> | |
| 24D. LOCATION (City, town, or county)
<i>Baltimore Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 30 1967</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. Finkbeiner</i> | | 25C. FUNERAL DIRECTOR
<i>Arlington Shields</i> ADDRESS <i>172 M. Moore St.</i> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>263 10313</u> |
|--|-------------------------|---|---|--|
| BIRTH NO. <u>67 10313</u> | | CERTIFICATE OF DEATH | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Carter, Mary Jane</u> | | |
| 2. DATE AND HOUR OF DEATH
<u>10/25/67 @ 1:35 AM</u> | | M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>90 Carver Nursing Home
607 Pennsylvania Avenue</u> | | A. STATE <u>Maryland</u>
B. COUNTY <u>12-07</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore, Maryland</u>
D. STREET ADDRESS (If rural, give location)
<u>2137 N. Howard St.</u> | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widower</u> | 8. DATE OF BIRTH
<u>2/7/1883</u> | 9. AGE (In years last birthday)
<u>84 yrs</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House Wife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
<u>Arnon Cornish</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>214-56-8949</u> | 17. INFORMANT ADDRESS
<u>William Cornish 1714 Moreland Ave.</u> | |
| 18. <u>422.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO <u>Lobar Pneumonia Rf.</u>
(B) DUE TO <u>Decompensated C.V. D.</u>
(C) <u>C.V. A. R. malnutrition</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-2-1966</u> to <u>10-25-1967</u> , that (I) (we) last saw the deceased alive on <u>10-25-1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Dr. Maybell Weaver</u> | | | 23B. DATE SIGNED
<u>10-26-67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>M. L. Weaver</u> | | | 23D. ADDRESS
<u>1944 Druid Hill Ave.</u> | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>10-28-67</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Mt. Auburn Cemetery</u> |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 30 1967</u> | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>Phillips 7 Home</u> | | |
| 25D. ADDRESS
<u>1727 Moreland</u> | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. X | |
|--|----------------------|---|--------------------------------------|--|---|
| BIRTH NO. 2-640 | | 67 10314 | | Certificate of Death | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | EARLE, CARVILLE R. | | OCTOBER 28, 1967 3:00 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

40 ST. AGNES HOSPITAL
CATON & WILKENS AVES
BALTIMORE, MARYLAND 21229 | | A. STATE MARYLAND 21229 B. COUNTY Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE Catonsville 53-00
D. STREET ADDRESS (If rural, give location) 410 OAK DRIVE Court | | | |
| 5. SEX

MALE | 6. RACE

WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED | 8. DATE OF BIRTH

07-22-21 | 9. AGE (In years lost birthday)

46 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

TEST DESK MAN | | 10B. KIND OF BUSINESS OR INDUSTRY

C & P TELEPHONE CO | | 11. BIRTHPLACE (State or foreign country)

MARYLAND | |
| 13. FATHER'S NAME

CARVILLE V. Earle | | | 14. MOTHER'S MAIDEN NAME

DORA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes W W II | | 16. SOCIAL SECURITY NO.

215-16-0596 | | 17. INFORMANT ADDRESS

ST. AGNES RECORDS CATON & WILKENS AVES | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>Acute Myocardial Infarction</i>
DUE TO
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION

0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)

<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>OCTOBER 22</u> 19 <u>67</u> to <u>OCTOBER 28</u> 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>OCTOBER 28</u> 19 <u>67</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE

<i>Carolyn Pass</i> | | | | 23B. DATE SIGNED

<i>10-28-67</i> | |
| 23C. PHYSICIAN'S NAME (Type)

CAROLYN PASS | | 23D. ADDRESS
M.D. ST. AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)

Burial | | 24B. DATE

10-30-67 | | 24C. NAME of CEMETERY or CREMATORY

Lake View Mem. Park Cem. | |
| 24D. LOCATION (City, town, or county) (State)

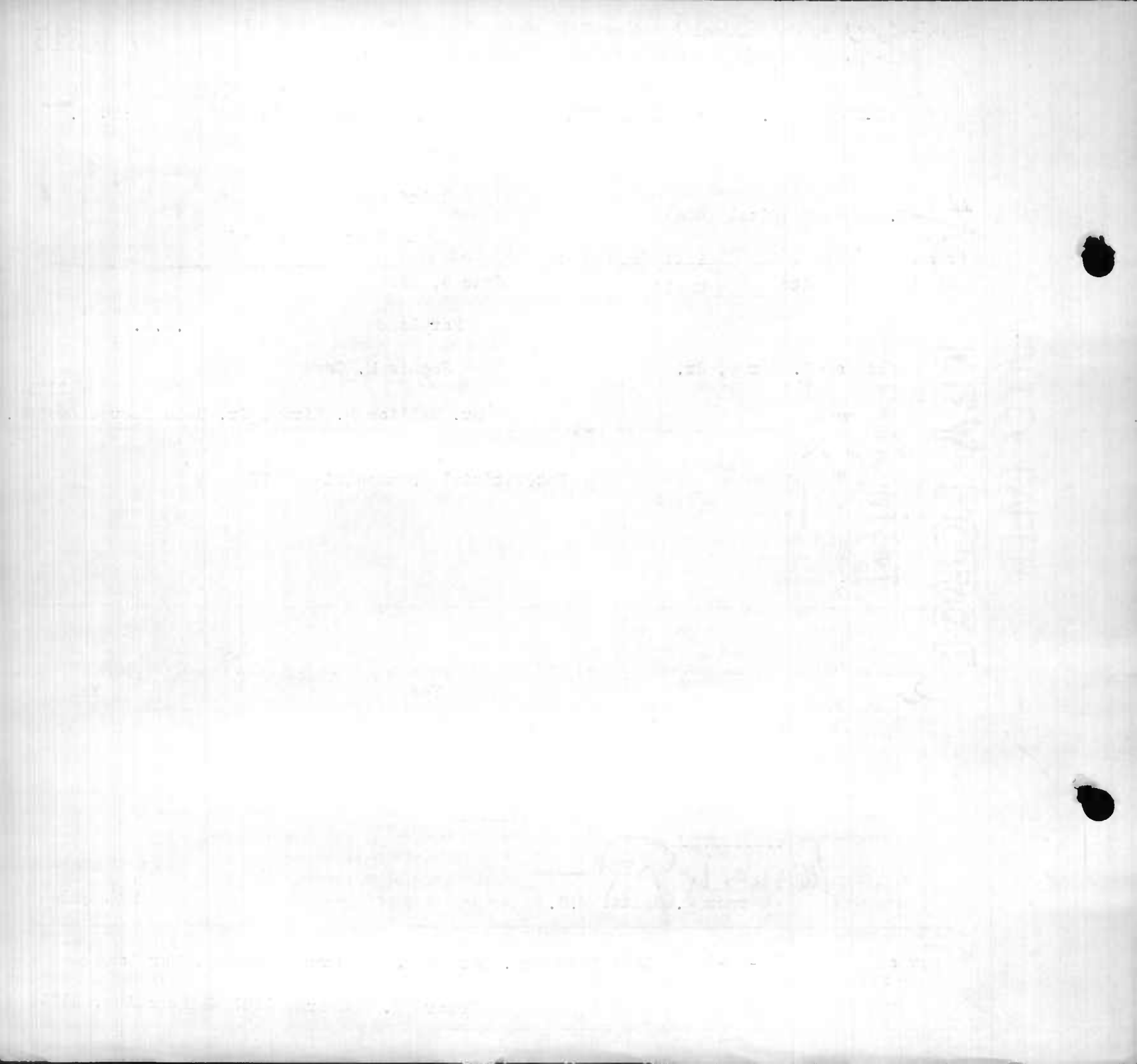
Carroll County, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.

OCT 30 1967 | | | |
| 25B. NAME OF REGISTRAR

<i>Robert E. Hubbard</i> | | 25C. FUNERAL DIRECTOR ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|--|---|--|---|--|---|--|
| K-610 | | 67 10315 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | Registered No. 67 10315 | |
| BIRTH NO. 67-11022 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
WILLIAM H. KIRBY III | | | | | 2. DATE AND HOUR PRONOUNCED DEAD
October 27, 1967 9:20 P. M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
St. Agnes Hospital (DOA) | | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
3010 Georgetown Road | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Child | | 8. DATE OF BIRTH
June 9, 1967 | 9. AGE (In years last birthday)
4 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
William H. Kirby, Jr. | | | | | 14. MOTHER'S MAIDEN NAME
Sophie M. Cavey | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mr. William H. Kirby, Jr. | | | ADDRESS
21230 3010 Georgetown Rd. | |
| 18. CAUSE OF DEATH | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>Antecedent Causes</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> </div> <div style="width: 50%;"> <p>(A) Interstitial Pneumonitis (SDII)</p> <p>DUE TO</p> <p>(B) _____</p> <p>DUE TO</p> <p>(C) _____</p> </div> </div> | | | | | | | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) | | (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| <p>22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> | | | | | | | | | |
| <p>ACTUAL SIGNATURE <i>Werner U. Spitz</i></p> <p>EXAMINER'S NAME (Type) Werner U. Spitz, M.D.</p> | | | | | <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p> | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
10-30-1967 | | 23C. NAME of CEMETERY or CREMATORY
Lake View Mem. Park Cem. | | | 23D. LOCATION (City, town, or county) (State)
Carroll County, Maryland | | |
| 24A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 24B. NAME OF REGISTRAR
<i>Robert E. Farley</i> | | | 24C. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 10316

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MATTIE SANDS

2. DATE AND HOUR PRONOUNCED DEAD

October 23, 1967 12:40 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

33
99 Johns Hopkins Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2312 Holyoke Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

8-5-80

9. AGE (In years
last birthday)

87

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

REGISTERED NURSE

10B. KIND OF BUSINESS OR INDUSTRY

SHEPPARD PRATT HOS.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

219-34-2232

17. INFORMANT

NORMAN L. Wilson

ADDRESS

2312 Holyoke Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 23, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

10-26-67

23C. NAME OF CEMETERY or CREMATORY

PARKWOOD CEMETERY

23D. LOCATION

(City, town, or county)

(State)

3310 Taybr Ave BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

OCT 30 1967

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

Philip E. Cyack

ADDRESS

1211 CHESACO AVE.

WILLIAM B. KELLEY

WILLIAM B. KELLEY

WILLIAM B. KELLEY

WILLIAM B. KELLEY

WILLIAM B. KELLEY

WILLIAM B. KELLEY

WILLIAM B. KELLEY

WILLIAM B. KELLEY

WILLIAM B. KELLEY

WILLIAM B. KELLEY

WILLIAM B. KELLEY

WILLIAM B. KELLEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

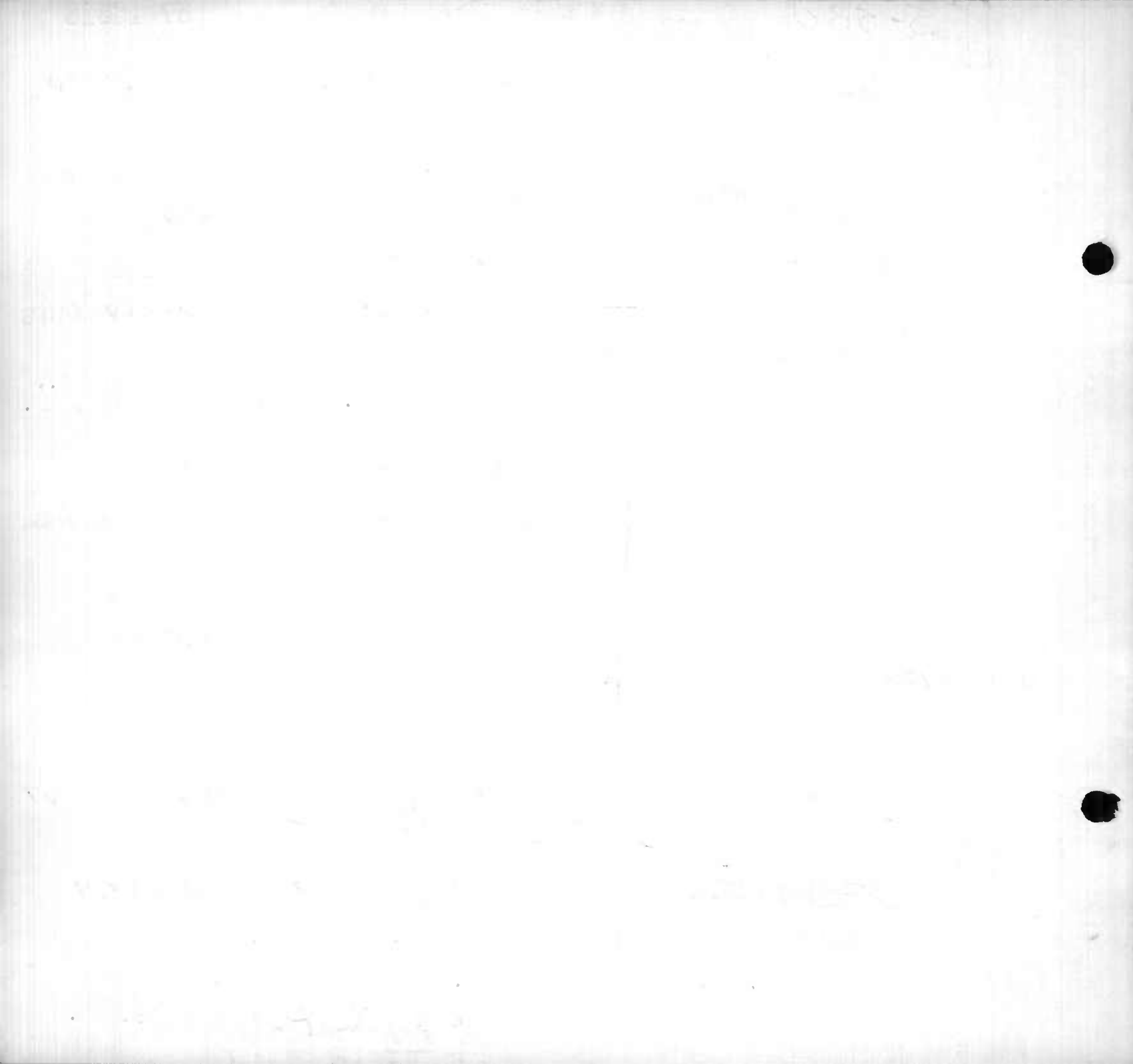
| Baltimore City Health Department | | | | Registered No. 67 10317 | |
|--|---|--|---|---|---|
| BIRTH NO. K-600 | | 67 10317 CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) John W. Kerr | | 2. DATE AND HOUR OF DEATH
10-26-67 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1103 S. Clinton St. | | A. STATE Md. B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto. 21224 26-11 | | | |
| | | D. STREET ADDRESS (If rural, give location)
1103 S. Clinton St. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
11-28-1902 | 9. AGE (In years last birthday)
64 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
Plate Mills | | 11. BIRTHPLACE (State or foreign country)
Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
Charles | | | |
| 14. MOTHER'S MAIDEN NAME
Myrtle Wheeler | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give woi or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-09-2803 | |
| 17. INFORMANT
Mrs. Esther Kerr | | ADDRESS
1103 S. Clinton St. | | | |
| 18. 151X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) starvation
DUE TO
(B) Ca of stomach
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
coronary insufficiency | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 1st 19 67 to Oct. 19 67 , that (I) (we) last saw the deceased alive on Oct 25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Rafael A. Santayana | | | | 23B. DATE SIGNED
Oct 27-1967 | |
| 23C. PHYSICIAN'S NAME (Type)
RAFAEL A. SANTAYANA | | | | 23D. ADDRESS
6010 Eastern Ave. BALTO. MD. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-30-67 | | 24C. NAME OF CEMETERY or CREMATORY
Oak Lawn | |
| 24D. LOCATION
Md. Balto. | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Thelma A. Hoffmann | | ADDRESS
3218 Hudson St | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

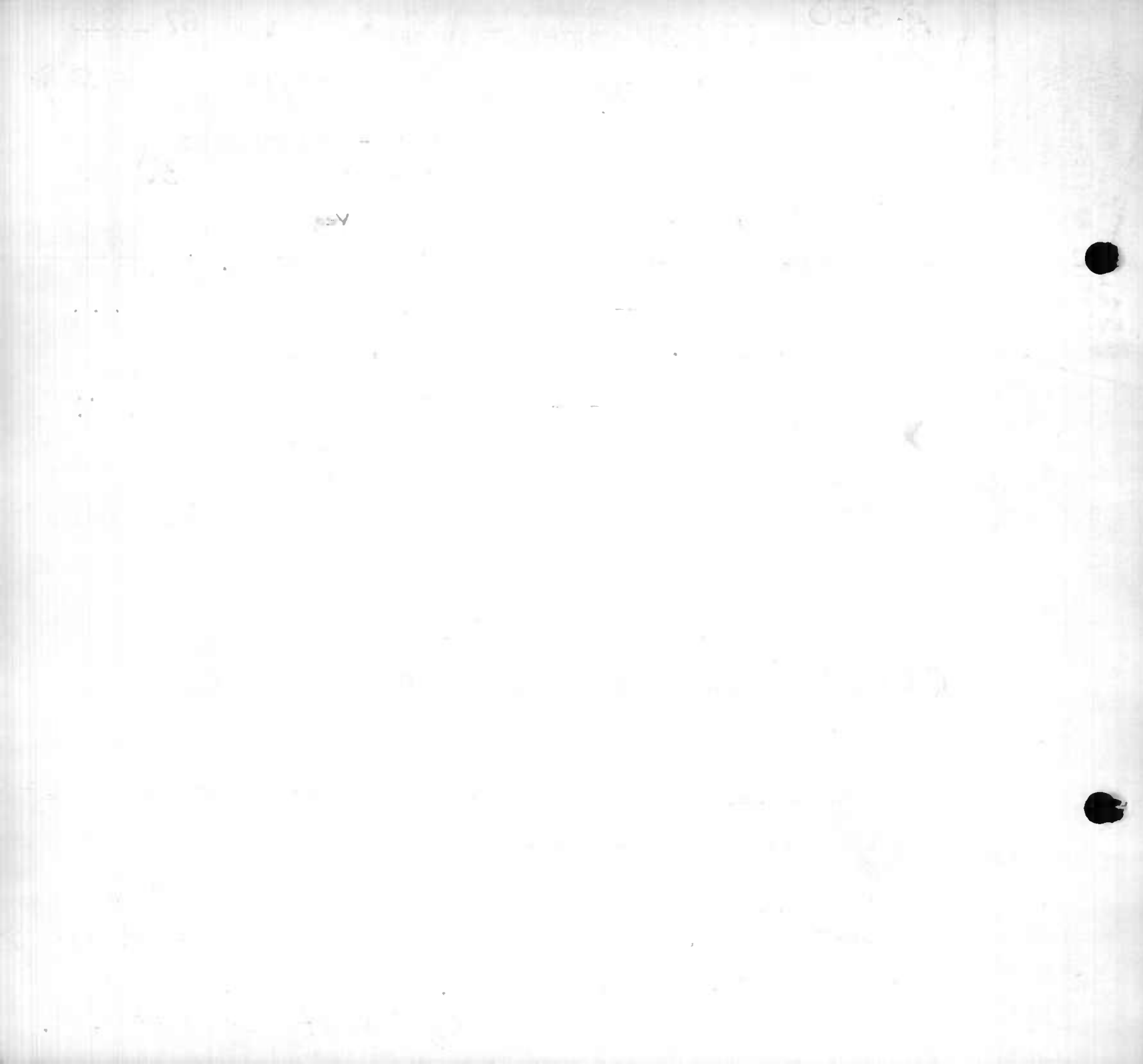
| | | | | | |
|---|--|---|--|--|--|
| BIRTH NO. 5-500 64-00321 67 10318 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10318 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) GLEN SMITH | | 2. DATE AND HOUR OF DEATH
10-27-67 2:50 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Owings Mills 53-00 | | D. STREET ADDRESS (If rural, give location)
102 WINGATE ROAD | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | (If not in hospital or institution, give street address or location) | | 5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married | |
| 8. DATE OF BIRTH 1-5-64 9. AGE (In years lost birthday) 3 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10B. KIND OF BUSINESS OR INDUSTRY --- | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 13. FATHER'S NAME LAWRENCE A. SMITH | | 14. MOTHER'S MAIDEN NAME Shirley Katherine Kennedy | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Lawrence A. Smith, 102 Wengate Rd., Owings Mills, Md. | | 18. 754.51 CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
PULMONARY INSUFFICIENCY
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
CONCENTRIC MITRAL STENOSIS 6 HRS. | |
| 19. DATE OF OPERATION 10-27-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED MITRAL STENOSIS | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 10-27-67 to 10-27-67 that the (we) last saw the deceased alive on 10-27-67 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Sherman G. Souther M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 10-27-67 | |
| 23C. PHYSICIAN'S NAME (Type) Sherman G. Souther | | 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Oct. 30, 1967 | | 24C. NAME OF CEMETERY or CREMATORY Lake View Mem. Park | |
| 24D. LOCATION (City, town, or county) (State) Sykesville, Maryland | | 25A. DATE REC'D. BY HEALTH DEPT. OCT 30 1967 | | 25B. NAME OF REGISTRAR Robert E. Farley | |
| 25C. FUNERAL DIRECTOR A. J. Schardt | | ADDRESS Owings Mills, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

| | | | | | | | |
|---|-------------------------|--|------------------------------------|--|----------------------------|---|-----------------------------|
| BIRTH NO. R-300 | | 67 10319 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10319 | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) RENNIE, BEVERLY | | | | 2. DATE AND HOUR OF DEATH
10/28/67 4:50 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
33 JOHNS HOPKINS HOSPITAL
601 North Broadway
Baltimore, Maryland 21205 | | (If not in hospital or institution, give street address or location) | | A. STATE
Maryland - Baltimore County | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Owings Mills 53-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
Timber Grove Road | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
4/12/26 | 9. AGE (In years last birthday)
41 yrs. | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
--- | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Carrick, Edward H. | | | | 14. MOTHER'S MAIDEN NAME
Grove, Dorothy | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
262-42-2804 | | 17. INFORMANT
Philip Rennie | | ADDRESS
Timber Grove Rd., Owings Mills, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
Cardiac Arrest | | | | INTERVAL BETWEEN ONSET AND DEATH
5 min. | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
II | | | | CAUSE OF DEATH
(A) DUE TO
Carcinoma of Breast - Metastatic 10 mos
(B) DUE TO
Anemia
(C) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
10/20/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cancer of Breast | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/19 19 67 to 10/28 19 67 , that (I) (we) lost saw the deceased alive on 10/28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Brent L. Horsley | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/28/67 | |
| 23C. PHYSICIAN'S NAME (Type)
BRENT L. HORSLEY | | | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Oct 31, 1967 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
A. J. Schmitt | | ADDRESS
Owings Mills, Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

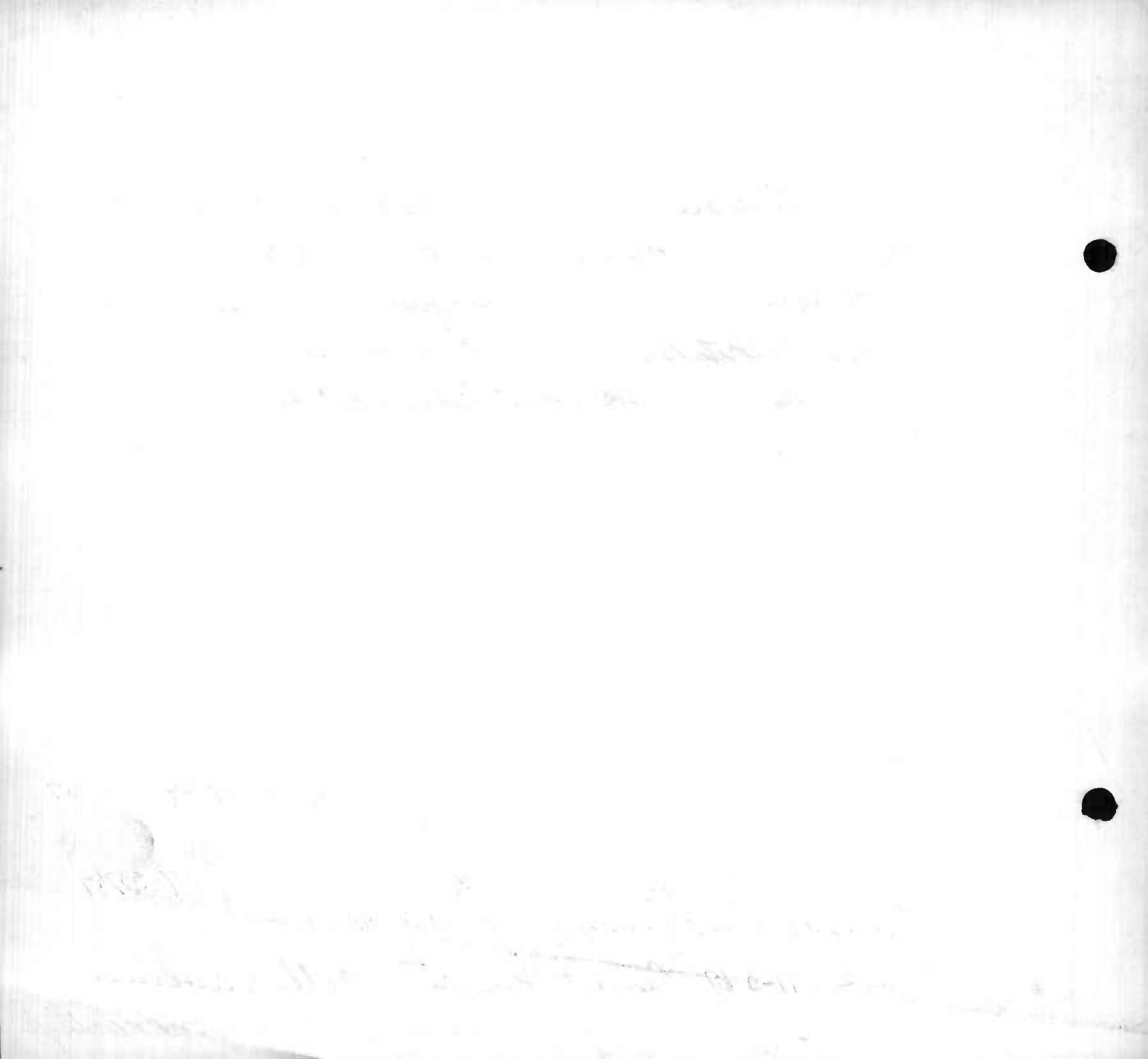
| | | | | | |
|---|-------------------------|---|------------------------------------|--|--|
| BIRTH NO. L-522 67 10320 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10320 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) MARTHENIA LANCASTER | | 2. DATE AND HOUR OF DEATH
10/29/67 11:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
1419 N. DUKELAND ST. #21216 | | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
1-15-90 | 9. AGE (In years lost birthday)
77 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA, Richmond | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
William Mamkin | | 14. MOTHER'S MAIDEN NAME
Henrietta Johnson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
217-54-4321 | | 17. INFORMANT ADDRESS
RECORDS-BCH-4940 EASTERN AVENUE | |
| 18. 331X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) CVA
(B) ASVD
(C) unknown | | INTERVAL BETWEEN ONSET AND DEATH
unknown | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from Sept. 12 19 67 to 10/29 19 67 and that (I) lost saw the deceased alive on 10/29 19 67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Raymond J. LaSure | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10-30-67 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. RAYMOND J. LA SURE | | 23D. ADDRESS
BCH-4940 EASTERN AVENUE, BALTIMORE, MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/4/67 | | 24C. NAME of CEMETERY or CREMATORY
East End Cemetery | |
| 24D. LOCATION
Richmond Virginia | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairburn | | 25C. FUNERAL DIRECTOR ADDRESS
Herbert E. Nutter-3035 W. North Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10321 | |
|--|---------------------|--|--------------------------------------|--|---|
| BIRTH NO. 67 10321 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) George H. Whitaker | | 2. DATE AND HOUR OF DEATH
October 29 1967 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
1826 E. Biddle St. Baltimore | | A. STATE Maryland
B. COUNTY Baltimore | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | D. STREET ADDRESS (If rural, give location)
1826 E. Biddle St. | | | |
| 5. SEX
Male | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
2-15-1904 | 9. AGE (In years last birthday)
63 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Labor | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Irish | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
James Whitaker | | 14. MOTHER'S MAIDEN NAME
Elvora H.C. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-10-1905 | | 17. INFORMANT
Hilda Whitaker | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Coronary Thrombosis | | CAUSE OF DEATH
(A) DUE TO
18. Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH
2 hrs | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9 24 1967 to 10 29 1967 , that (I) (we) last saw the deceased alive on 9 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Reed R. Reford | | | | 23B. DATE SIGNED
10 30 67 | |
| 23C. PHYSICIAN'S NAME (Type)
DR ALBERT L. LAFORREST | | | | 23D. ADDRESS
822 N. BROAD ST | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-2-67 | | 24C. NAME OF CEMETERY or CREMATORY
Pleasant Hill Cmt | |
| 24D. LOCATION (City, town, or county) (State)
North Carolina | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 30 1967 | | | |
| 25B. NAME OF REGISTRAR
George E. Giddens | | 25C. FUNERAL DIRECTOR
Choy Wilson and Brantley | | | |



1
L-000

67 10322 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10322

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN LEE

2. DATE AND HOUR PRONOUNCED DEAD

October 25, 1967 1:05 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1219 N. Luzerne Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1219 N. Luzerne Ave.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 20, 1909

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Season

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Joe Lee

14. MOTHER'S MAIDEN NAME

Emma Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

May Bailey

ADDRESS

Same

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 25, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10-31-67

23C. NAME OF CEMETERY or CREMATORY

Arbutus Cent

23D. LOCATION (City, town, or county) (State)

Lanham Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 30 1967

Chas. S. Springate

Chas. S. Springate 1000 Brantley Ave

James
of the
James
James
James

James

James
of the
James
James
James

James
of the
James
James
James

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10323

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

NORMA RATHER

2. DATE AND HOUR PRONOUNCED DEAD

October 22, 1967 12:45 pm.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1023 N. Wolfe Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov 7 1939

9. AGE (In years last birthday)

28

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James Jenkins

14. MOTHER'S MAIDEN NAME

Alfreda Auston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

John Jones 1018 E 20th St

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)(A) Acute intoxication by Doriden
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1023 N. Wolfe Street

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

10 21 67

?

m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Took overdose of Doriden

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

October 23, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

10-26-67

23C. NAME OF CEMETERY or CREMATORY

Mt Airy Cemetery

23D. LOCATION (City, town, or county) (State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

Oct 30 1967

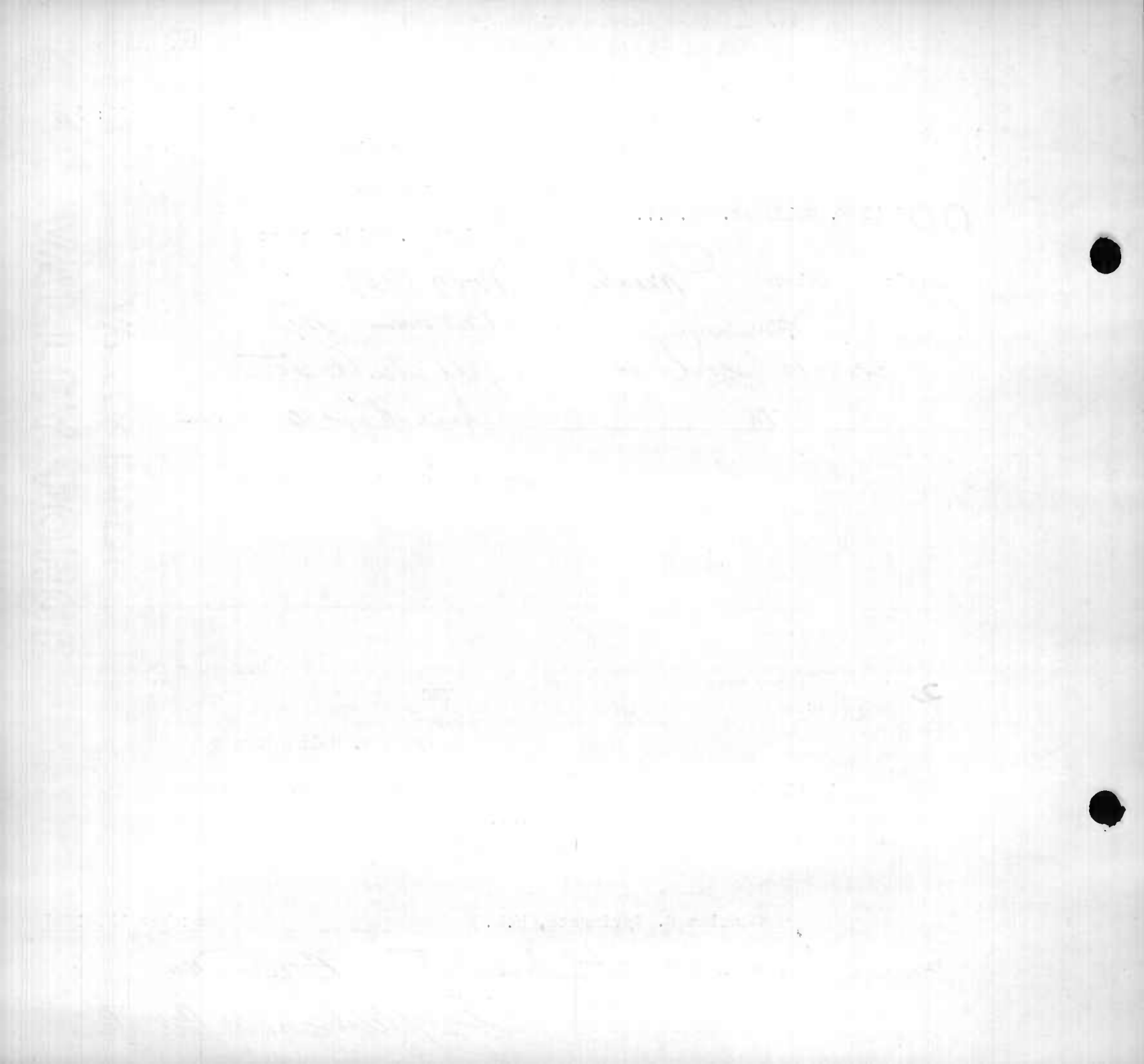
24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

Elroy Wilson 1000 Brantley Ave

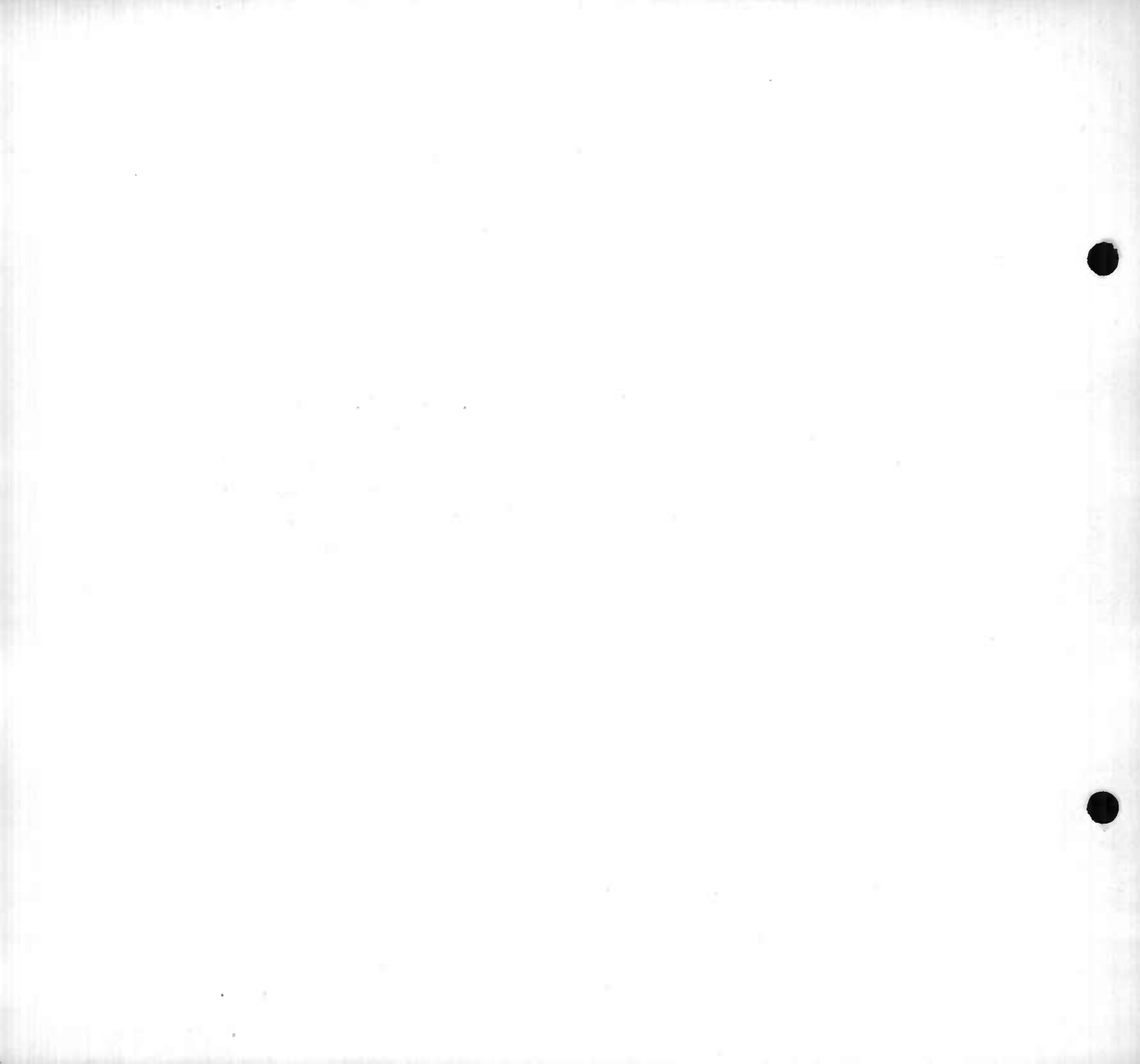
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

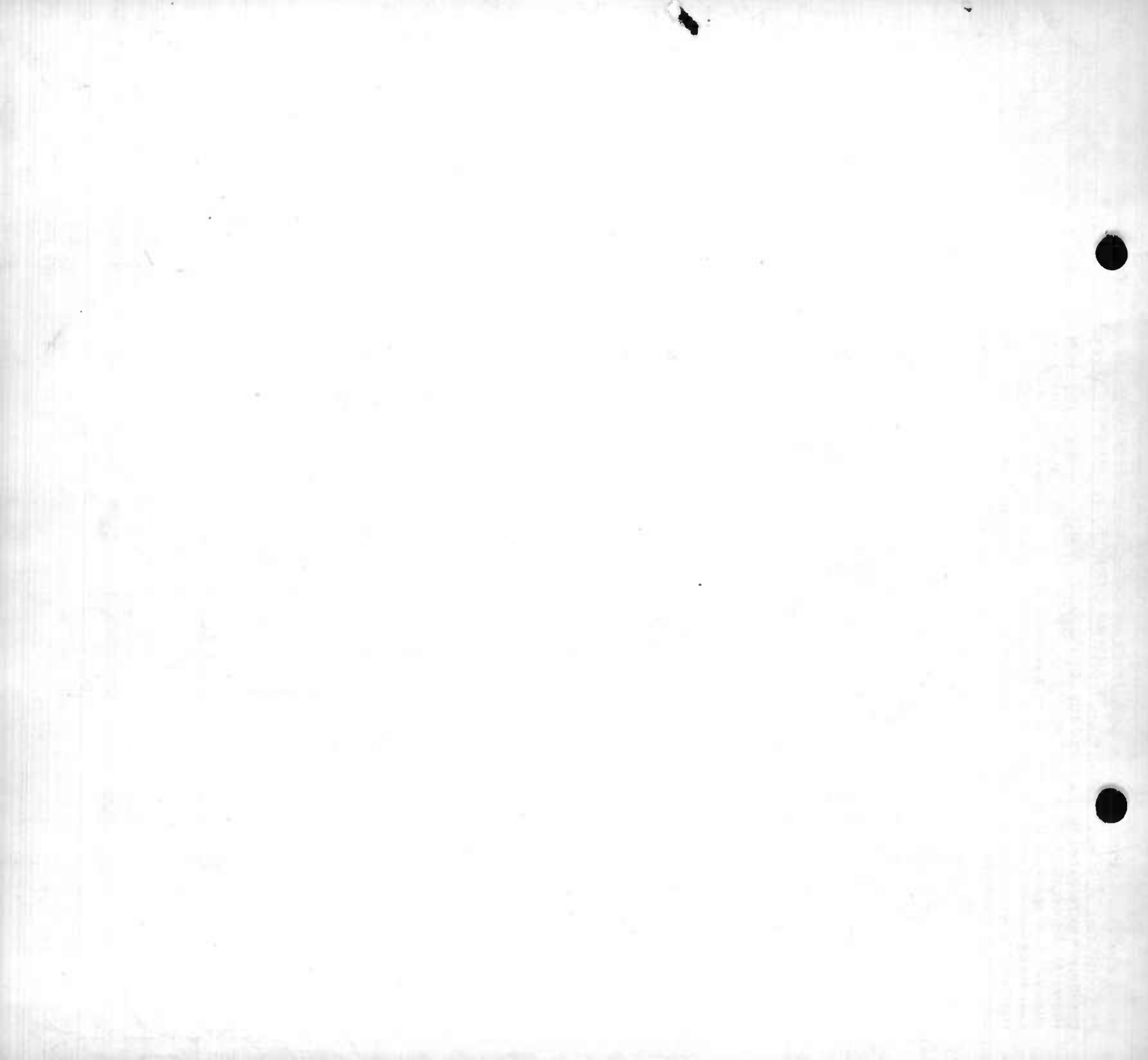
| | | | | | |
|--|----------------------|--|--|---|--|
| BIRTH NO. 67 10324 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10324 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) <u>Ethel M. Powell</u> | | |
| 2. DATE AND HOUR OF DEATH <u>10-30-67</u> <u>2:35 P.M.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>43 South Baltimore General Hosp.</u> | | | A. STATE <u>Maryland</u> B. COUNTY <u>24-04</u> | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> # <u>21230</u> | | | D. STREET ADDRESS (If rural, give location) <u>233 E. Heath St.</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u> | 8. DATE OF BIRTH <u>6-30-1902</u> | 9. AGE (In years last birthday) <u>65</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor Lady-Hosiery</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | | 13. FATHER'S NAME <u>Richard Croke</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Catherine Fewer</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>220 07 4614</u> | | 17. INFORMANT ADDRESS <u>Mr. George A. Powell</u> <u>Same</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | (A) <u>SCHIRROUS CA. OF BREAST & UNDIFFERENTIATED CARCINOMA OF OVARY WITH WIDESPREAD METASTASIS TO CHEST & ABDOMEN</u> | | |
| ANTECEDENT CAUSES | | | (B) DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) <u>ABDOMEN</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>10-24-67</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>he</u> (this hospital) attended the deceased from <u>10-24-67</u> to <u>10-30-67</u> , that <u>we</u> last saw the deceased alive on <u>10-30-67</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Larry J. Warner M.D.</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>10-30-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Larry J. Warner</u> M.D. | | | | 23D. ADDRESS <u>1213 Light St.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>11 3 67</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u> | |
| 24D. LOCATION (City, town, or county) <u>Balto. Md.</u> | | (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>OCT 31 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Faldut</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Mc Gully 130 E. Fort Ave</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | 4 | |
| BIRTH NO. <u>67-21076</u> <u>67 10325</u> | | REGISTERED NO. <u>101408</u>
<u>67 10325</u> | |
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Baby Boy DEVAULT</u> | | 2. DATE AND HOUR OF DEATH
<u>10-28-67</u> <u>5:40 A.M.</u> | |
| 3. PLACE OF DEATH <u>BALTIMORE, MARYLAND</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>5.</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>34 BON SECOURS</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>28 S. Carrollton Ave</u> | |
| 5. SEX <u>M</u> | 6. RACE <u>N</u> | 7. MARRIED, <u>NEVER MARRIED</u>
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
<u>10-27-67</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>none</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>none</u> | 9. AGE (In years last birthday)
<u>Y</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>30 m/s</u> |
| 11. BIRTHPLACE (State or foreign country)
<u>Ind.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>ALEXANDER DEVAULT</u> | | 14. MOTHER'S MAIDEN NAME
<u>PHYLLIS SIMMONS</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>✓</u> | | 16. SOCIAL SECURITY NO.
<u>✓</u> | 17. INFORMANT
<u>MOTHER</u> |
| 18. <u>773.5 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>Myocardial Infarction Disease</u>
DUE TO
(B) <u>Myocardial</u>
DUE TO
(C) _____ | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
<u>2</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
<u>✓</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>✓</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-27</u> <u>1967</u> to <u>10-28</u> <u>1967</u> , that (I) <u>(ye)</u> last saw the deceased alive on <u>10-28</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(ye)</u> (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<u>Alayne A. Melocaton</u> | | 23B. DATE SIGNED
<u>10-28-67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>ALAYNE A. MELOCATON, D.O.</u> | | 23D. ADDRESS
<u>BON SECOURS HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>10/30/67</u> | 24C. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cem.</u> | 24D. LOCATION (City, town, or county) (State)
<u>Pitchee Hwy</u> <u>MD.</u> |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 31 1967</u> | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, Jr.</u> | 25C. FUNERAL DIRECTOR
<u>John J. Cowan & Son, Inc.</u> | |
| ADDRESS
<u>23 W. 901 S. Hollins St.</u> | | | |



| | | | | | | | |
|---|---------|--|---|---|--|--|--|
| 1 | | 67 10326 | | BALTIMORE CITY HEALTH DEPARTMENT | | 67 10326 | |
| G-536 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| | | | | HERMAN Johnson GENTRY | | October 28, 1967 6:28 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| South Baltimore Hospital (DOA) | | | | Maryland Anne Arundel Co. | | | |
| | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| | | | | Arundel Gardens | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 402 Cresswell Ave. 21225 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | |
| Male | White | Married | June 20, 1926 | 41 | Boiler maker | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Boiler maker | | | Yadkinville, N. C. | | U. S. A. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | | |
| Marvin Gentry | | | Virney Johnson | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| Yes | | | 243-32-5597 | | Mr. Lee Gentry 3800 Brooklyn Ave. | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | Cranio-Cerebral Injury | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (C) DUE TO | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | Home | | 402 Creswell Road | | 52-00 | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Apparently fell after ingestion of alcohol. | | | |
| 10/28/67 6:00 P. | | | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 10/29/67 | | | |
| Werner U. Spitz, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Burial | | 11/1/67 | | Meadowridge Memorial Park | | Howard Co. Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| OCT 31 1967 | | Robert E. Farley | | McElly F. Home | | 21225 237 Patapsco Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

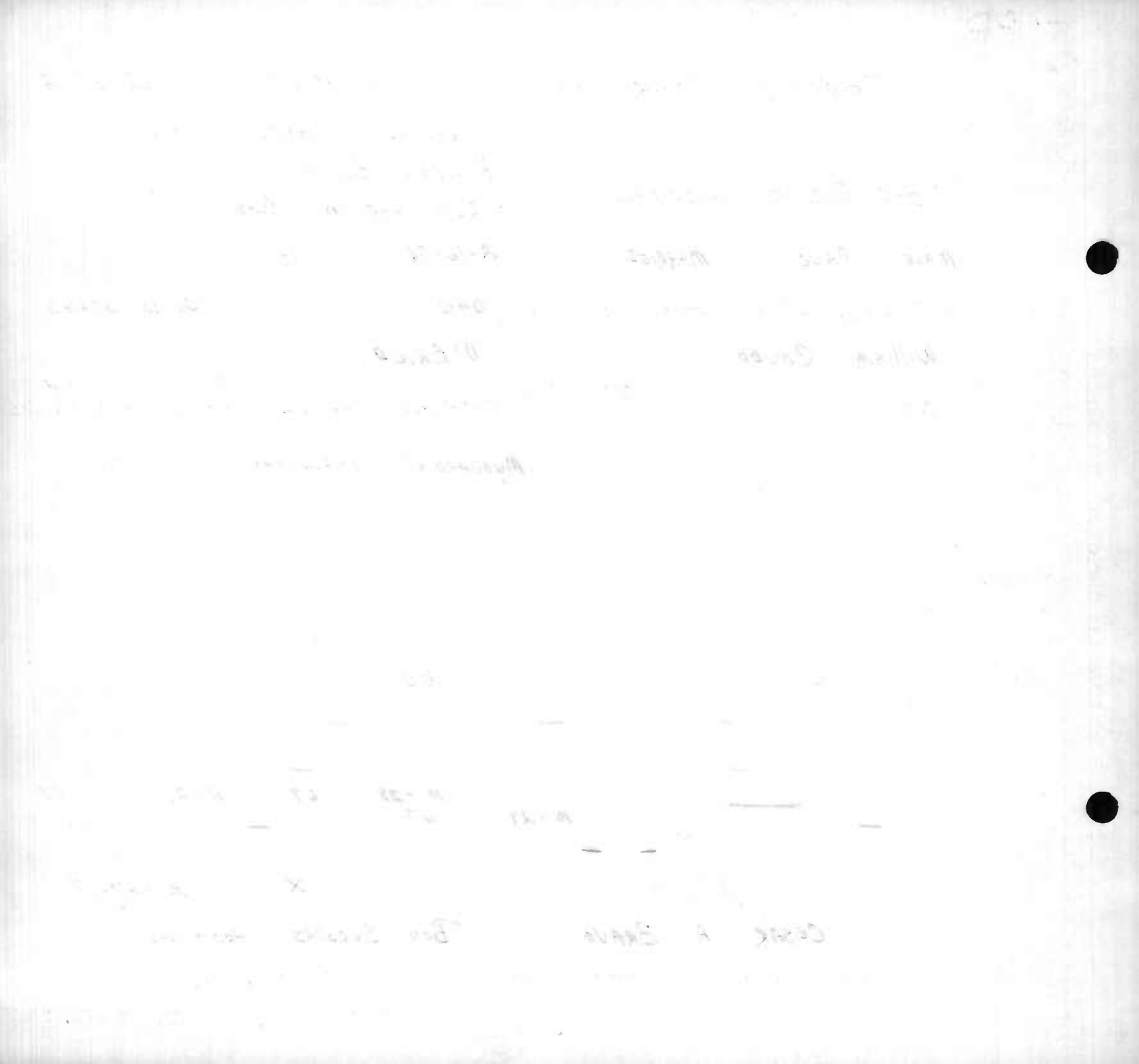
| | | | | | |
|--|-----------------------------|---|--|--|---|
| BIRTH NO. 67 10327 | | Baltimore City Health Department
CERTIFICATE OF DEATH | | Registered No. 67 10327 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) VINCENT BALDASSARE | | | 2. DATE AND HOUR OF DEATH
29 OCT 67 10¹⁵ A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
37 Mercy Hospital
(If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 21225 25-04 | | |
| D. STREET ADDRESS (If rural, give location)
904 Jeffrey Street | | | | | |
| 5. SEX
M | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
11-15-97 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Stone Mason | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Italy | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 13. FATHER'S NAME
Vincent Baldassare | | | 14. MOTHER'S MAIDEN NAME
Theresa ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
Mrs. Rose Baldassare 904 Jeffrey St. 21225 | | |
| 18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ACUTE MYOCARDIAL INFARCTION - 12 HRS. -
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ARTIO SCLEROTIC CARDIOVASCULAR - YEARS -
O B E S I T Y | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 2/4 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 12⁰⁰ AM 29 OCT 1967 to 10¹⁵ AM 29 OCT 1967 , that the (we) last saw the deceased alive on 10⁰⁰ AM 29 OCT 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) not view the body after death. | | | | | |
| 23A. SIGNATURE
Salvatore R. Donohue M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
29 OCT 67 | |
| 23C. PHYSICIAN'S NAME (Type)
SALVATORE R. DONOHUE | | 23D. ADDRESS
MERCY HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
11/2/67 | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | 25B. NAME OF REGISTRAR
Robert E. F... | | 25C. FUNERAL DIRECTOR ADDRESS
McCurly Funeral Home 237 Patapsco Ave. 21225 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10328 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10328 | | | |
|---|--|-----------------------------|--|---|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) THOMAS F. CHUBB SR. | | | | | | | | 2. DATE AND HOUR OF DEATH
10/29/67 12:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

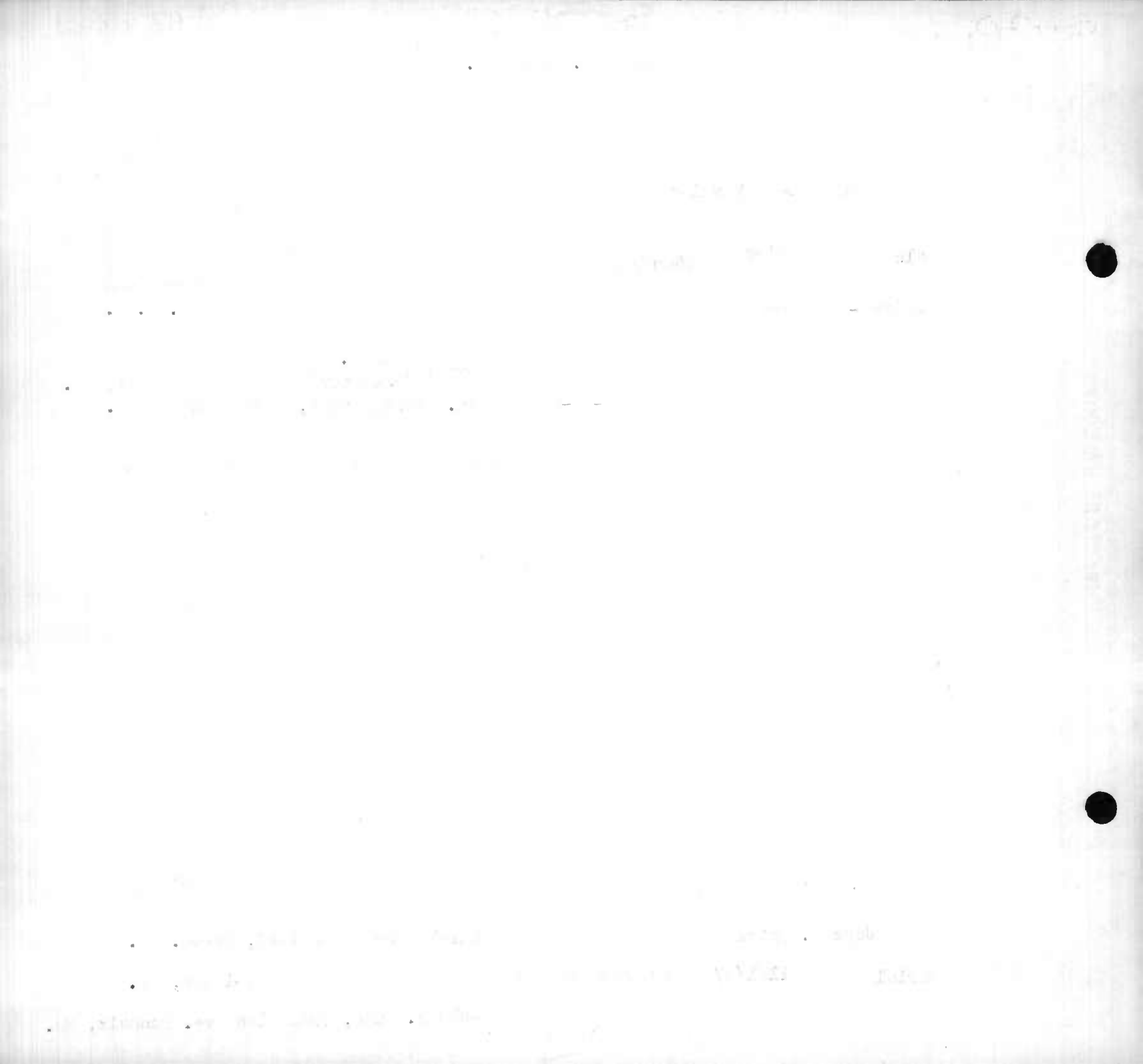
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
34 BON SECOURS HOSPITAL | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY ANNE ARUNDEL Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) RIVIERA BEACH 52-00
D. STREET ADDRESS (If rural, give location) 267 HARLEM ROAD | | | |
| 5. SEX
MALE | | 6. RACE
CAUC. | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
2-16-94 | | 9. AGE (In years last birthday)
73 | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RET. INSPECTOR | | | | 10B. KIND OF BUSINESS OR INDUSTRY
GENERAL MOTORS | | | | 11. BIRTHPLACE (State or foreign country)
OHIO | | 12. CITIZEN OF WHAT COUNTRY?
UNITED STATES | |
| 13. FATHER'S NAME
William Chubb | | | | | | 14. MOTHER'S MAIDEN NAME
O'BRIEN, ELIZ. | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
2720 93204 | | 17. INFORMANT
FLORENCE Chubb, 267 HARLEM Rd RIVIERA BEACH Md | | | | | |
| 18. 4-20-11 CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Myocardial INFARCTION
DUE TO
(A) Myocardial INFARCTION
(B)
(C)
INTERVAL BETWEEN ONSET AND DEATH
hours | | | | | | | | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
NO | | | | 20A. AUTOPSY? (Yes or No)
NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
— | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)
— | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR?
— | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-28 19 67 to 10-29 19 67 , that (I) (we) lost saw the deceased alive on 10-29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Cesar A. Bravo M.D. | | | | | | | | 23B. DATE SIGNED
10-29-67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
CESAR A. BRAVO M.D. | | | | | | | | 23D. ADDRESS
BON SECOURS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
11/2/67 | | 24C. NAME of CEMETERY or CREMATORY
CALVERY CEMETERY | | | | 24D. LOCATION (City, town, or county) (State)
CLEVELAND, OHIO | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | | | 25B. NAME OF REGISTRAR
Robert E. Fairburn | | | | 25C. FUNERAL DIRECTOR
HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10329 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10329 | |
|--|---------|--|-----------------------------------|--|---|--|------------------------------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | James F. Burge Sr. | | 10-28-67 6:10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 35 Church Home & Hospital | | | | MARYLAND, BALTIMORE Co. | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Dundalk 53-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 3301 Belsford Court | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| Male | White | Married | 5-18-14 | 53 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Retired- Postman | | | | | WEST VIRGINIA | | U. S. A. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| HENRY BURGE | | | | Ella B. FUNK | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT (Daughter) ADDRESS | |
| No | | | | 755-09-0743 | | Dundalk, Md. | |
| | | | | Mrs. Brenda Knott, 7800 Lockwood Rd. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 3 81.01 | | | | (A) CARDIO-RESPIRATORY ARREST DUE TO | | 4 hrs. | |
| ANTECEDENT CAUSES | | | | (B) HEPATO-RENAL FAILURE DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) CIRRHOSIS OF THE LIVER | | | |
| II | | | | ACUTE GASTRIC DILATATION; HYPVOLEMIA; STRESS ULCER | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 10-25-67 | | RECURRENT VENTRAL HERNIA | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-13 1967 to 10-28 1967, that (I) (we) last saw the deceased alive on 10-28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Jose Y. Ortiz | | | | | | 10-28-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Jose Y. Ortiz | | | | Church Home & Hospital, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 11/1/67 | | Oak Lawn Cemetery | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| OCT 31 1967 | | John J. Duda | | John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------------|--|--|--|------------------------------------|---|------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT | | 67 10330 | | CERTIFICATE OF DEATH | | Registered No. 67 10330 | |
| BIRTH NO. 67 10330 | | | | M.E. CASE NO. Mary E. Medlin | | | |
| 1. NAME OF DECEASED (Type or Print) MARY E. MEDLIN | | | | 2. DATE AND HOUR OF DEATH Oct 28, 1967 16:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Church Home + 35 Hospital | | | | A. STATE Md. B. COUNTY Baltimore Co. | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - Edgemere 53-00 | | | |
| D. STREET ADDRESS (If rural, give location) 28 Platt Lane | | | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH 12/18/18 | 9. AGE (In years last birthday) 48 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Cecil Earl Obinovskay | | | | 14. MOTHER'S MAIDEN NAME Brazil Cook | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 238-09-5046 | | 17. INFORMANT (Husband) 21219 | |
| 18. 199-21 | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) Metastatic Carcinoma | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DUE TO | | | |
| (C) | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 22 1967 to Oct 28 1967, that (I) (we) last saw the deceased alive on Oct 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE J.A. Baltazar, Jr. | | | | | | 23B. DATE SIGNED Oct 28, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) FRANCISCO A BALTAZAR | | | | | | 23D. ADDRESS Church Home + Hosp 100 N. Broadway | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 11/1/67 | | 24C. NAME OF CEMETERY OR CREMATORY Bessemer City Cemetery | | 24D. LOCATION (City, town, or county) (State) Bessemer City, North Carolina | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 31 1967 | | 25B. NAME OF REGISTRAR Robert E. Fairbairn | | 25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. | | ADDRESS | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10331

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPHINE VIRGINIA YEATMAN

2. DATE AND HOUR PRONOUNCED DEAD

October 27, 1967 10:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - Dundalk

D. STREET ADDRESS (If rural, give location)

8000 Kavanagh Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 3, 1910

9. AGE (In years
last birthday)

57

11. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Lewis F. James

14. MOTHER'S MAIDEN NAME

Rose Anna Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT (Husband) Dundalk, Md. 21222
Mr. Charles L. Yeatman, 8000 Kavanagh Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
If in Baltimore City, give exact location)21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/27/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/30/67

23C. NAME of CEMETERY or CREMATORY

Cedar Hill Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE RECEIVED BY HEALTH DEPT.

OCT 31 1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

ADDRESS

John J. Duda, Dundalk, Md. 21222

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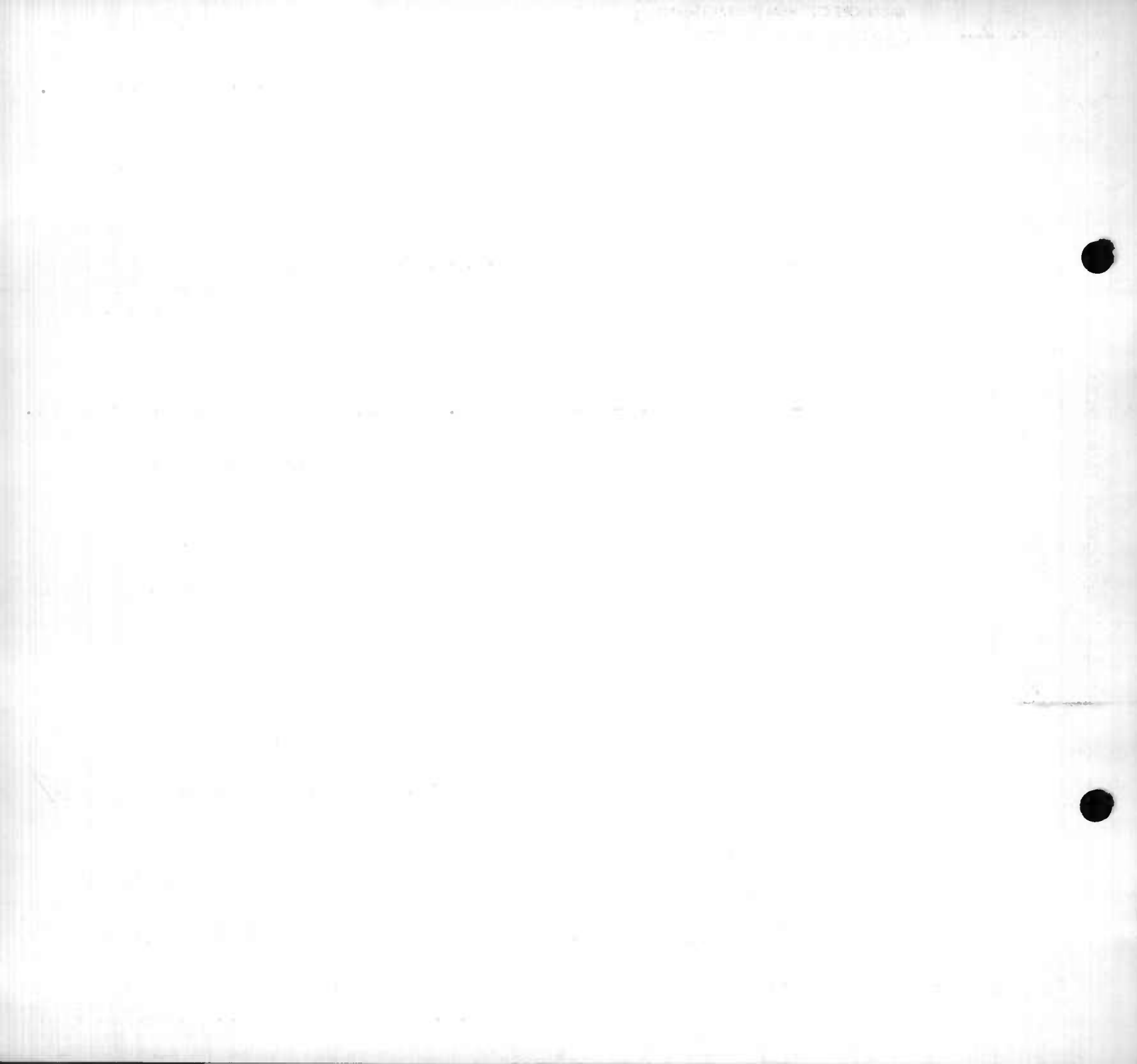
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------|--|---------------------------|--|--|
| BIRTH NO. 67 10332 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10332 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) ALPHONSE RYKACZEWSKI | | 2. DATE AND HOUR OF DEATH
October 29, 1967 1 2:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
00 705 N. Curley Street | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 7-01
705 N. Curley Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 10/12/04 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman | | 10B. KIND OF BUSINESS OR INDUSTRY Ship Cargo Loading | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Cornelius Rykaczewski | | 14. MOTHER'S MAIDEN NAME Pauline Kryszkiewicz | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No - | | 16. SOCIAL SECURITY NO. 215-05-3336 | | 17. INFORMANT Mrs. Isabelle Tribull, 705 N. Curley St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.0 I
DUE TO
Anterior & lateral heart failure
INTERVAL BETWEEN ONSET AND DEATH 5 yr. | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| (B) DUE TO | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/25 6/4 1966 to 10/25 1967, that (I) (we) last saw the deceased alive on 10/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Irwin B. Kaplan | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 10/31/67 | |
| 23C. PHYSICIAN'S NAME (Type) IRWIN B. KAPLAN | | 23D. ADDRESS 129 S Broadway Baltimore, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 11/2/67 | | 24C. NAME OF CEMETERY or CREMATORY Holy Rosary | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. OCT 31 1967 | | 25B. NAME OF REGISTRAR Robert E. Fisher | |
| 25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE | | 25D. ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10333 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10333 | |
|---|-----------------------------|---|---------------------------------------|---|----------------------------|--|-----------------------------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) <i>LOUISE J. BOARMAN</i> | | 2. DATE AND HOUR OF DEATH
<i>10-27-67</i> <i>100/p</i> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>48 Maryland General Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>Baltimore Co.</i>
C. CITY OR TOWN (If outside-city limits, write RURAL and give township)
<i>Baltimore</i> <i>53-00</i>
D. STREET ADDRESS (If rural, give location)
<i>2906 DUNNAN ROAD #22</i> | | | |
| 5. SEX
<i>FEMALE</i> | 6. RACE
<i>CAUCASIAN</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>MARRIED</i> | 8. DATE OF BIRTH
<i>12/25/1899</i> | 9. AGE (In years lost birthday)
<i>67</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>HOUSEWIFE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>at home</i> | | 11. BIRTHPLACE (State or foreign country)
<i>MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | |
| 13. FATHER'S NAME
<i>LOUIS LEITMAN</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Charlotte Kolb</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>no</i> | | 16. SOCIAL SECURITY NO.
<i>212-09-483</i> | | 17. INFORMANT
<i>William Boarman, husband, above</i> | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>ACUTE PERITONITIS</i>
DUE TO
<i>RADIATION PROCTITIS & PERI-RECTAL ABSCESS</i>
DUE TO
<i>CARCINOMA of CERVIX</i> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<i>10/16/67</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>FAC</i> | | 20A. AUTOPSY? (Yes or No)
<i>yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-16</i> <i>1967</i> to <i>10-27</i> <i>1967</i> , that (I) (we) last saw the deceased alive on <i>10-27</i> <i>1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Donald B. Webb</i> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>10/31/67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>New Cathedral Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Balto., Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 31 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, MA</i> | | 25C. FUNERAL DIRECTOR
<i>Schimunek Funeral Home</i>
<i>3331 Brehms Lane #13</i> | | ADDRESS | |

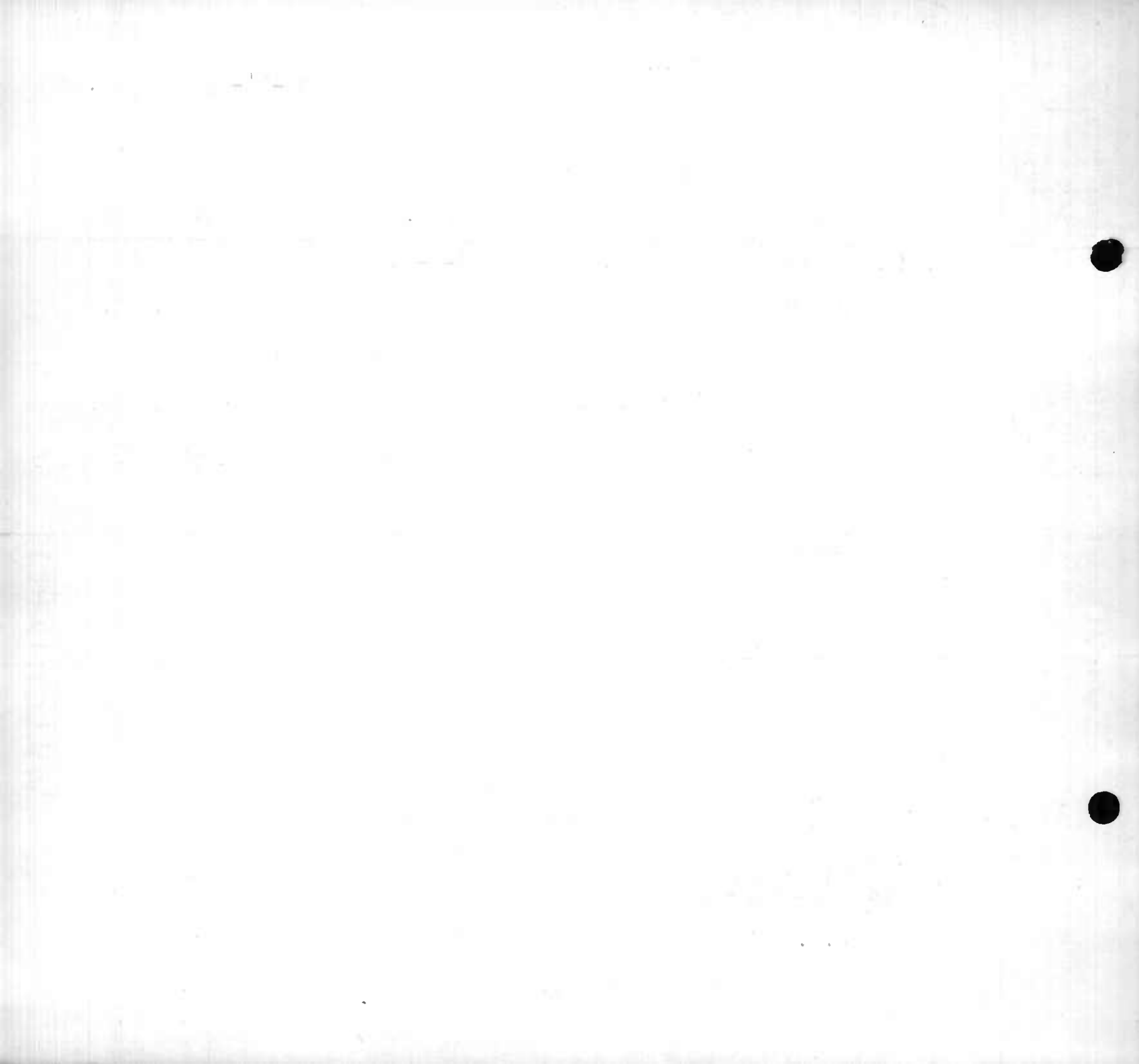
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118 71 87 R
GREENBERG, GUSTAV

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|-----------------------------------|---|---|
| BIRTH NO. G-651 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10334 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | GUSTAV A.
GUSTAV GREENBERG | | 2. DATE AND HOUR OF DEATH
10-28-67 12.45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE
MARYLAND
B. COUNTY
BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | D. STREET ADDRESS (If rural, give location)
205 N. STREEPER STREET | | 21224 | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
1-2-91 | 9. AGE (In years
last birthday)
76 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Stationery Engineer | | 10B. KIND OF BUSINESS OR INDUSTRY
A & P | | 11. BIRTHPLACE (State or foreign country)
Sweden (Stockholm) | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
GUSTAV
GUSTAV GREENBERG | | 14. MOTHER'S MAIDEN NAME
CAROLYN PETERSON | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
214-03-3983 | | 17. INFORMANT
Matilda Student Greenberg, wife, above | |
| 18. 177X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
CARCINOMA of PROSTATE 2 YRS. | | 19. II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (A) (this hospital) attended the deceased from 25 OCT 19 67 to 28 OCT 19 67 , that (B) (we) last saw the deceased alive on 27 OCT 19 67 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J.C. WHITE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
28 OCT. | |
| 23C. PHYSICIAN'S NAME (Type)
J.C. WHITE | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/31/67 | | 24C. NAME of CEMETERY or CREMATORY
Parkwood Cemetery | |
| 24D. LOCATION
Baltimore, Md. | | 24E. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | | |
| 24F. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 24G. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc. | | | |
| 24H. ADDRESS
3331 Brehms Lane | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|---|--|---|--|
| BIRTH NO. 67 10335 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10335 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED Walter | | 2. DATE AND HOUR OF DEATH 10/29/67 1:45 P.M. | |
| 1. NAME OF DECEASED (Type or Print) Mr. James Buck | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hosp. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY - | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO | |
| D. STREET ADDRESS (If rural, give location) 1017 S. Ellwood Ave | | 5. SEX M | | 6. RACE W | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | | 8. DATE OF BIRTH 11/5/94 | | 9. AGE (in years last birthday) 72 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Chemical | | 10B. KIND OF BUSINESS OR INDUSTRY Allied Chemical | | 11. BIRTHPLACE (State or foreign country) Poland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME Charles Buck | | 14. MOTHER'S MAIDEN NAME Tomczak | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215632084 | | 17. INFORMANT ADDRESS CHART Md General | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) DUE TO | | Bronchogenic Carcinoma 2 yrs | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2/19/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA. of Lung | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/11/67 to 10/27/67, that (I) (we) last saw the deceased alive on 10/25/67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Frank J. Zorick M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) FRANK J. ZORICK M.D. | | | | 23D. ADDRESS Md. Gen'l Hosp. | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 11/2/67 | | 24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 24E. DATE REC'D BY HEALTH DEPT. 11/1/67 | | 24F. NAME OF REGISTRAR J. E. Fadden | |
| 25A. DATE REC'D BY HEALTH DEPT. 11/1/67 | | 25B. NAME OF REGISTRAR J. E. Fadden | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane | |

Ret. Chemical Aff'd (final)

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TS/12/18

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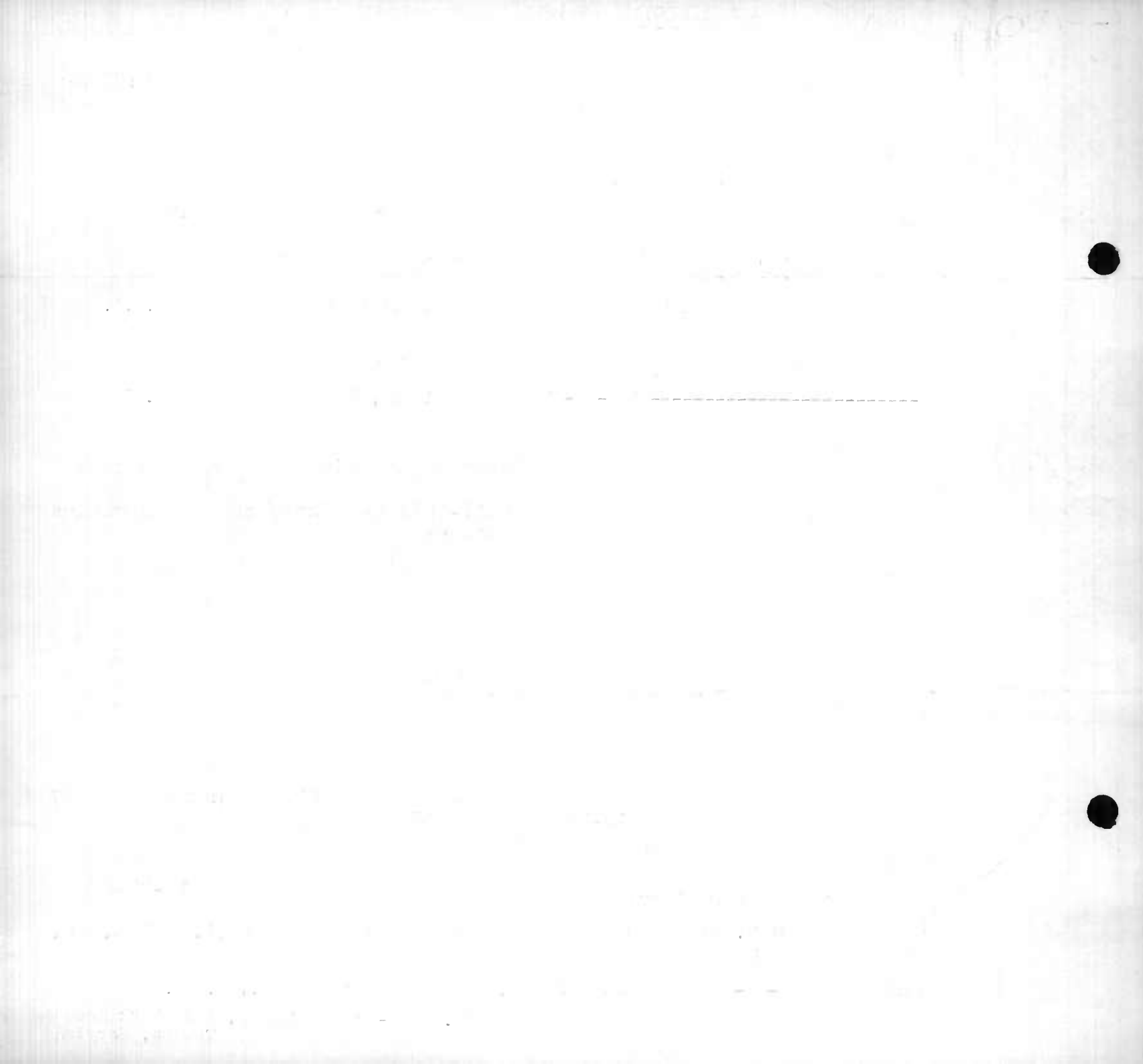
Wm. A. Foster

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10336 | |
|---|---------|--|--------------------------|--|--------------------------------|
| 67 10336 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| William Goff | | 10-27-67 | | 5:30 AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| THE JOHNS HOPKINS HOSPITAL
33 | | MARYLAND BALTIMORE Co. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | EDGEWARE | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 7409 ROBERTS AVE 21219 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| MALE | WHITE | SINGLE | 6-4-14 / 15 | 55 52 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | Railroad | | West Virginia | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| CHARLES GOFF | | | MYRTLE THOMAS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 235-18-6201 | | Roy Gillum, 7409 North Point Rd. 21219 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | 5 days | |
| ANTECEDENT CAUSES | | (B) DUE TO | | 2 months | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 9-25-19 67 to 10-27-19 67, that (X) (we) last saw the deceased alive on 10-27-19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (view) the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| John V. Russo | | | | 10-27-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| John V. Russo | | | | Johns Hopkins Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 10-31-67 | | Woodring Chapel, | |
| | | | | Preston Co., W. Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| OCT 31 1967 | | Robert E. Fairburn | | Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10337 | |
|---|---------------------|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 10337 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) <i>Sheppard, Sarah E.</i> | | | 2. DATE AND HOUR OF DEATH
<i>10-30-67 4:45 A.M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>Bon Secours Hospital</i>
<i>34</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>
D. STREET ADDRESS (If rural, give location) <i>26-44 6 N Kresson Street</i> | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>MARRIED</i> | 8. DATE OF BIRTH
<i>9-24-93</i> | 9. AGE (In years last birthday)
<i>74</i> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | 11. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> |
| 13. FATHER'S NAME
<i>Brown, Joseph</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Barrett</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | 16. SOCIAL SECURITY NO.
<i>NONE</i> | | 17. INFORMANT
<i>Admission Sheet</i> |
| 18. CAUSE OF DEATH
I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)
<i>Arteriosclerosis & V Disease</i>
(A) DUE TO
<i>Cerebrovascular Accident</i>
(B) DUE TO
(C) | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
<i>years.</i>
<i>days.</i> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <i>10/22</i> 19 <i>67</i> to <i>10/30/67</i> 19 <i>67</i> , that (I) (<u>we</u>) last saw the deceased alive on <i>10/29</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (<u>did not</u>) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Cesar A. Bravo</i> M.D. | | | | 23B. DATE SIGNED
<i>10/30/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>CESAR A. BRAVO</i> | | | 23D. ADDRESS
<i>Bon Secours Hospital</i> M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11/1/67</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Meadowridge Memorial Pk. Elkridge Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>Oct 31 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fairbank</i> | | 25C. FUNERAL DIRECTOR
<i>Robt H Ware</i> ADDRESS
<i>Bingleton Funeral Home / 1409 Burrell St.</i> | |

3408

[Faint handwritten notes at the bottom of the page, likely bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10338 | |
|--|------------------|--|----------------------------------|--|---|
| 67 10338 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) Vernon Armacost Mathias | | 2. DATE AND HOUR OF DEATH
10-27-67 8:35 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
38 University of Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Carroll Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Westminister 56-27
D. STREET ADDRESS (If rural, give location) 50 Poolz Rd. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 10-12-97 | 9. AGE (In years lost birthday) 70 | If Under 1 Yr. Months: Days: Hours: Min.
0 15 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Farmer | | 11. BIRTHPLACE (State or foreign country) Westminister | |
| 13. FATHER'S NAME J. Mathias | | 14. MOTHER'S MAIDEN NAME Lizzie Armacost | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. 218-36-6264 | | 17. INFORMANT ADDRESS
Mrs Helen S. Mathias Same address | |
| 18. 434117260X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
PULMONARY EDMA | | CAUSE OF DEATH
(A) DUE TO PULMONARY EDMA | | INTERVAL BETWEEN ONSET AND DEATH 2-3 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Congestive Heart Failure | | (C) 2-3 wks | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | DIABETES MELLITUS | | 30 yrs | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-24 19 67 to 10-27 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE J. E. Fryer, Jr. | | | | 23B. DATE SIGNED 10-27-67 | |
| 23C. PHYSICIAN'S NAME (Type) J. E. Fryer, Jr. | | 23D. ADDRESS University of MD Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10/30/67 | | 24C. NAME OF CEMETERY Miller Mem. Cemetery Rural, Westminister, Md. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. OCT 31 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley, Jr. | | 25C. FUNERAL DIRECTOR ADDRESS J. E. Fryer, Jr., Westminister, Md. | | | |

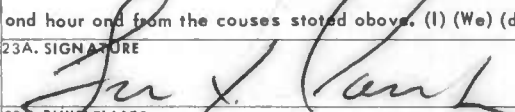
General 1/30/67 Miller from London, New York, Washington, D.C.
2. 1/30/67 P. Washington, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|-----------------------------------|--|---|
| 67 10339 | | BALTIMORE CITY HEALTH DEPARTMENT | | 67 10339 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| LAURA D. BARNES BARNES | | October 9, 1967 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

2834 N. Calvert Street | | A. STATE
Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
2834 N. Calvert Street | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Nov. 11, 1901 | 9. AGE (In years lost birthday)
65 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Parsons, West Virginia | |
| 13. FATHER'S NAME
Franklin A. Crosten | | 14. MOTHER'S MAIDEN NAME
Martha Koontz | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No No | | 16. SOCIAL SECURITY NO.
234-32-2685 | | 17. INFORMANT
Mr. O'Gill Barnes, 2834 N. Calvert St. Balto., Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Carcinoma of Rectum
DUE TO
(B)
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | | | 23B. DATE SIGNED
10-9-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Francis X. Carmody | | 23D. ADDRESS
3503 Barclay St., Baltimore, Md. 21216 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-12-67 | | 24C. NAME OF CEMETERY OR CREMATORY
Oxford Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Oxford Chester Co., Pa. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Wm. Q. Johnston, Oxford, Pa. | |

John T. Hart

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------------|--|-----------------------------------|--|----------------------------|---|-----------------------------|
| BIRTH NO. 7-612 | | 67 10340 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10340 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) MATTIE L. TRAVIS | | | | 2. DATE AND HOUR OF DEATH
10/29/67 8:00 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
FRANKLIN SQ. HOSP. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto 19-01
D. STREET ADDRESS (If rural, give location)
408 N. STRICKER ST. | | | |
| 5. SEX
F | 6. RACE
N | 7. MARRIED NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
5/5/05 | 9. AGE (In years last birthday)
62 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY
BUTTON HOLE FACT | | 11. BIRTHPLACE (State or foreign country)
GEORGIA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
LESTER WIMBERLY | | | | 14. MOTHER'S MAIDEN NAME
LAURA - | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No 20-10-61/9 | | | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT ADDRESS
Records with the Travis 408 N. Stricker St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Biliary Obstruction secondary to Carcinoma of Pancreas. | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
1 year. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| (C) DUE TO | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/11 19 67 to 10/29 19 67 , that (I) <u>(we)</u> last saw the deceased alive on 10/29 19 67 and that (in my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> view the body after death. | | | | | | | |
| 23A. SIGNATURE
Hector L. Feliciano | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/29/67 | |
| 23C. PHYSICIAN'S NAME (Type)
HECTOR L. FELICIANO | | | | 23D. ADDRESS
FRANKLIN SQ. HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burn | | 24B. DATE
11/4/67 | | 24C. NAME OF CEMETERY or CREMATORY
Carver Mem. Park | | 24D. LOCATION (City, town, or county) (State)
MURKIN MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
Marion P. Hays | | ADDRESS
638 N. Calumet St | |

of the
of the

25

for the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10341 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10341 | |
|--|--|---|--|---|--|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) LOUISA De Leo (LUIA) | | | | 10-27-67 | | 8:57 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE MD
B. COUNTY | | | |
| 35 Church Home & Hospital | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| 35 Church Home & Hospital | | | | D. STREET ADDRESS (If rural, give location)
3255 E. BALTIMORE ST | | | |
| 5. SEX
F | | 6. RACE
W | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
M | | 8. DATE OF BIRTH
12-16-90 | |
| 9. AGE (In years last birthday)
76 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE wife | | 11. BIRTHPLACE (State or foreign country)
Italy | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
JOSEPH DEFRANCESCO | | | | 14. MOTHER'S MAIDEN NAME
ALICEA NEED | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
213-89-3695 | | 17. INFORMANT
PATIENT | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CA, Sigmoid Colon | | | | INTERVAL BETWEEN ONSET AND DEATH
? | | 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerotic Heart Disease?
BRONCHIAL ASTHMA | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cerebral Hypoxia | | | | 20. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 19A. DATE OF OPERATION
10-12-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
CA, Sigmoid Colon | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-1-67 19 67 to 10-27 19 67 , that (I) (we) lost saw the deceased alive on 10-27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Asst. M.D. | | | | | | 23B. DATE SIGNED
10-27-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. John Rosin | | | | 23D. ADDRESS
CH & H | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/30/67 | | 24C. NAME OF CEMETERY or CREMATORY
Oak Lawn | | 24D. LOCATION (City, town, or county) (State)
Balt. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Dr. E. E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
Joseph J. Jannard 263 S. Conkling St. | | | |

George W. W. W.

12-18-92

Alfred J. J.
Patient

Joseph D. D.
Home wife

213-22-2892

CA, Edward L. L.
Petrochemical Heart Disease
Bronchial Asthma

Edward L. L.
CA

CA, Edward L. L.

12-18-92

10-27-92

10-1-92

10-27

Edward L. L.
CA. John L. L.

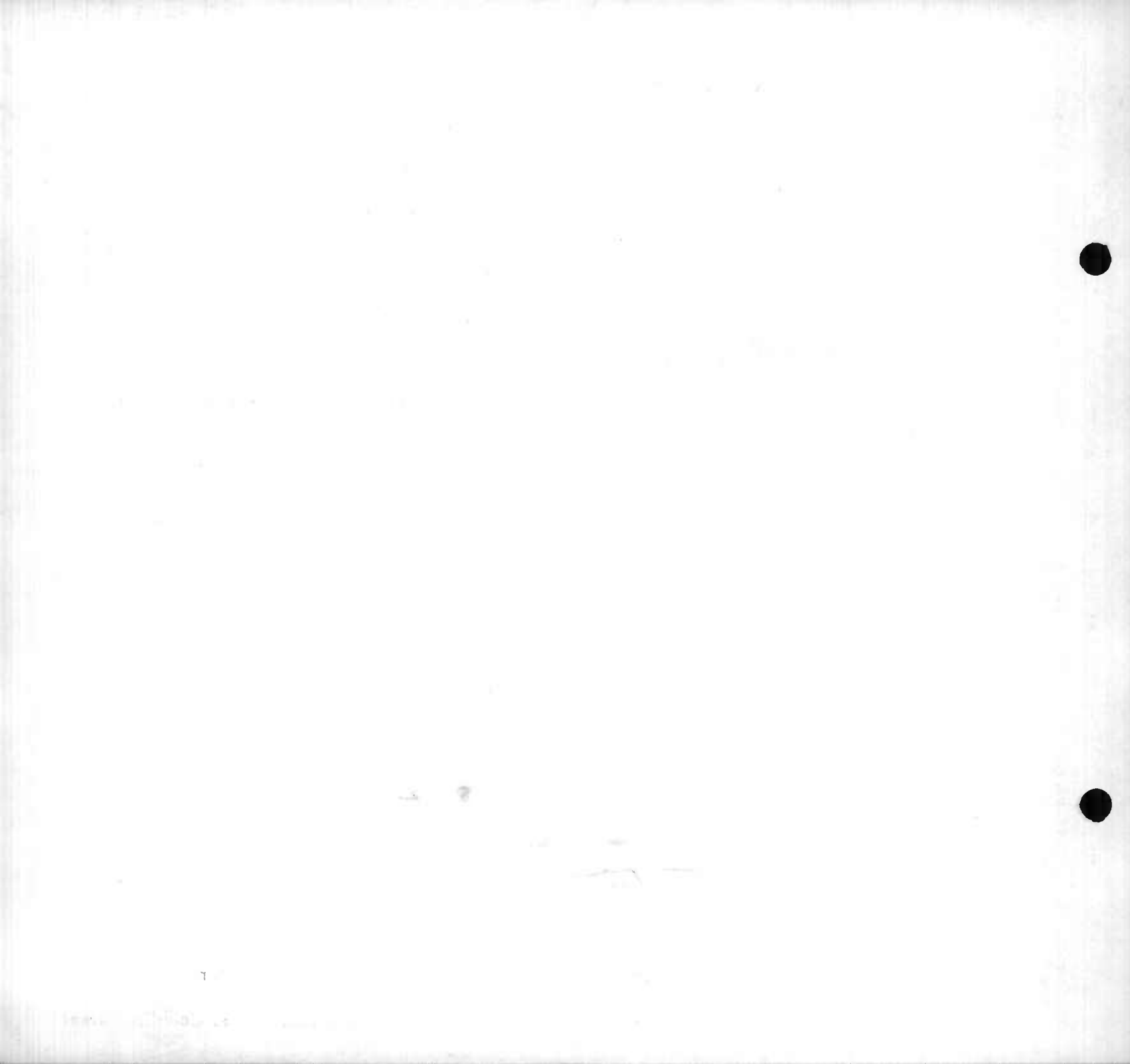
CA. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10342 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10342 | |
|--|---------------|--|---|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Catherine (Katy) Miller-Mueller | | | | 2. DATE AND HOUR OF DEATH
October 26, 1967 7 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3730 E. Lombard Street | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-08
D. STREET ADDRESS (If rural, give location)
3730 E. Lombard Street | | | |
| 5. SEX F | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1/7/05 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto., Maryland | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME William Bennett | | | | |
| 14. MOTHER'S MAIDEN NAME Ida Hunter | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS Mr. John Miller 3730 E. Lombard Street | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Primary Carcinoma of Bowel
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Mild Diabetes | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-2 1967 to 10-26-67 19, that (I) (we) last saw the deceased alive on 10-25-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John Costantino, M.D. | | | | 23B. DATE SIGNED 10-29-67 | | | |
| 23C. PHYSICIAN'S NAME (Type) John Costantino, M.D. | | | | 23D. ADDRESS 34 S. CONKLING ST. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10/30/67 | | 24C. NAME OF CEMETERY or CREMATORY Sacred Heart | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 31 1967 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Joseph N. Zannino, 263 S. Conkling Street | | ADDRESS | |



1
B-525

67 10343 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10343

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLENA

BENJAMIN

2. DATE AND HOUR PRONOUNCED DEAD

October 28, 1967

3:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 726 Aisquith St. (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

726 Aisquith Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Separated

8. DATE OF BIRTH

12/15/15

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Willie Whittington

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Sara Scott, 1705 Etting St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/28/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

11/1/67

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetry

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

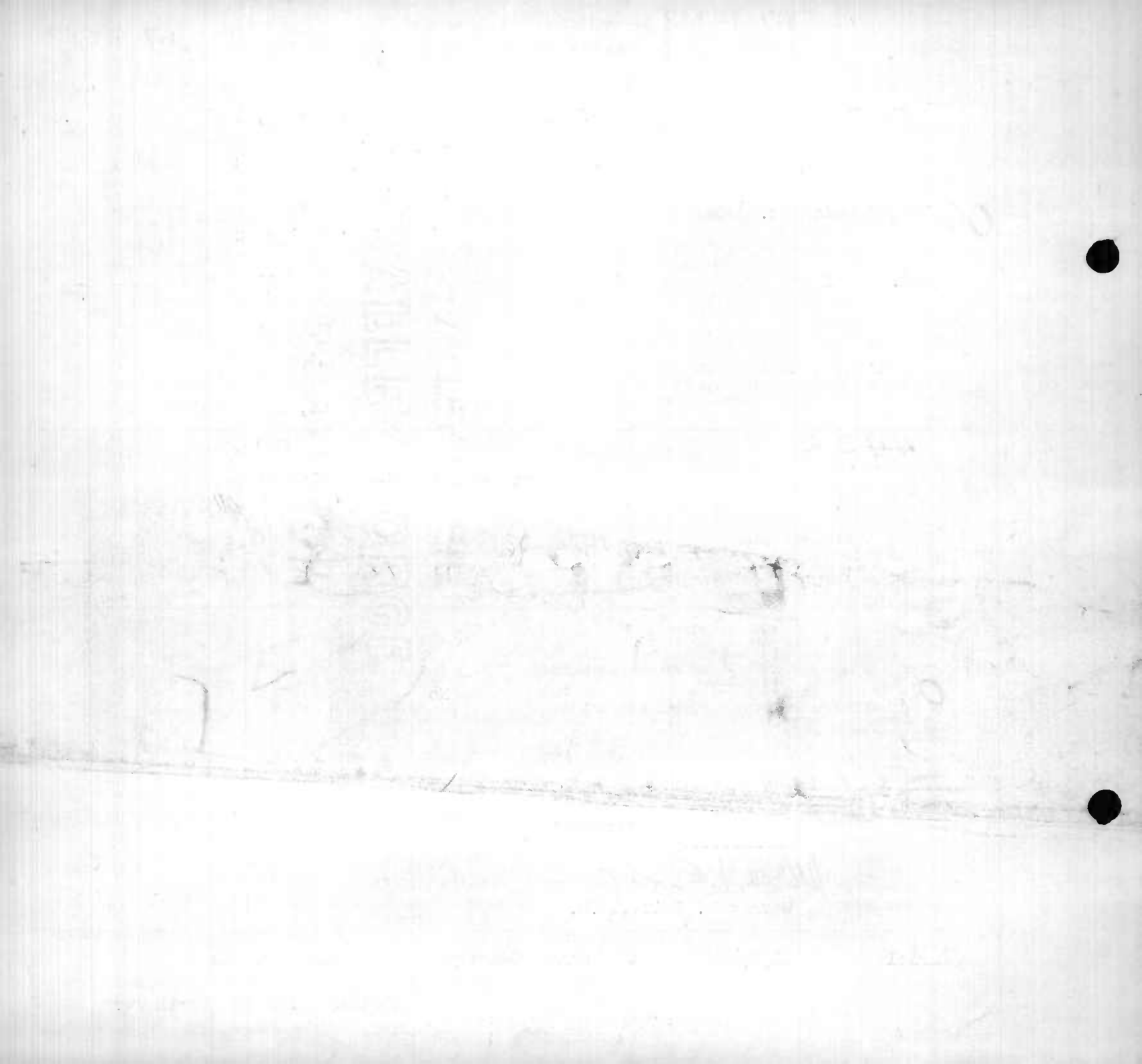
24C. FUNERAL DIRECTOR

ADDRESS

OCT 31 1967

Ruth E. Fashola

A Halstead 1206 W North Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 10344 | | Registered No. 67 10344 | |
|--|--|---|--|---|--|--|--|
| BIRTH NO. | | 67 10344 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | SMITH JOSEPHINE | |
| 2. DATE AND HOUR OF DEATH | | 10/27/67 | | 6 | | A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| LUTHERAN HOSPITAL OF MARYLAND | | | | B MARYLAND | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED NEVER MARRIED
WIDOWED DIVORCED (specify) | | 8. DATE OF BIRTH | |
| F | | C | | WIDOWED | | 5-11-93 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Old Age | | | | Va | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | | | LAURA SMITH | | 1100 DUKELAND ST. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| 422.1 I | | | | ASCVD WIT | | | |
| ANTECEDENT CAUSES | | | | Congestive Cardiac Failure | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | PULMONARY EDEMA | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-26-1967 to 10-27-1967, that (I) (we) last saw the deceased alive on 10-27-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| V. Biswanath Pillai | | | | 10/27/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| V. BISWANATH PILLAI | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 10/31/67 | | Mt. Calvary Cemetery | | A A County Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| OCT 31 1967 | | Robert E. Falgout | | A.olphus Halstead | | 1206 W North Ave | |

1
K-500

67 10345 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 10345

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE KANE

2. DATE AND HOUR PRONOUNCED DEAD

October 19, 1967

3:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 540 W. Lanvale Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

540 W. Lanvale Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

217-09-3930

17. INFORMANT

18. ADDRESS

Ms Ann K cpherson, 946 Druid Hill Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springgate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 19, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10/31/67

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

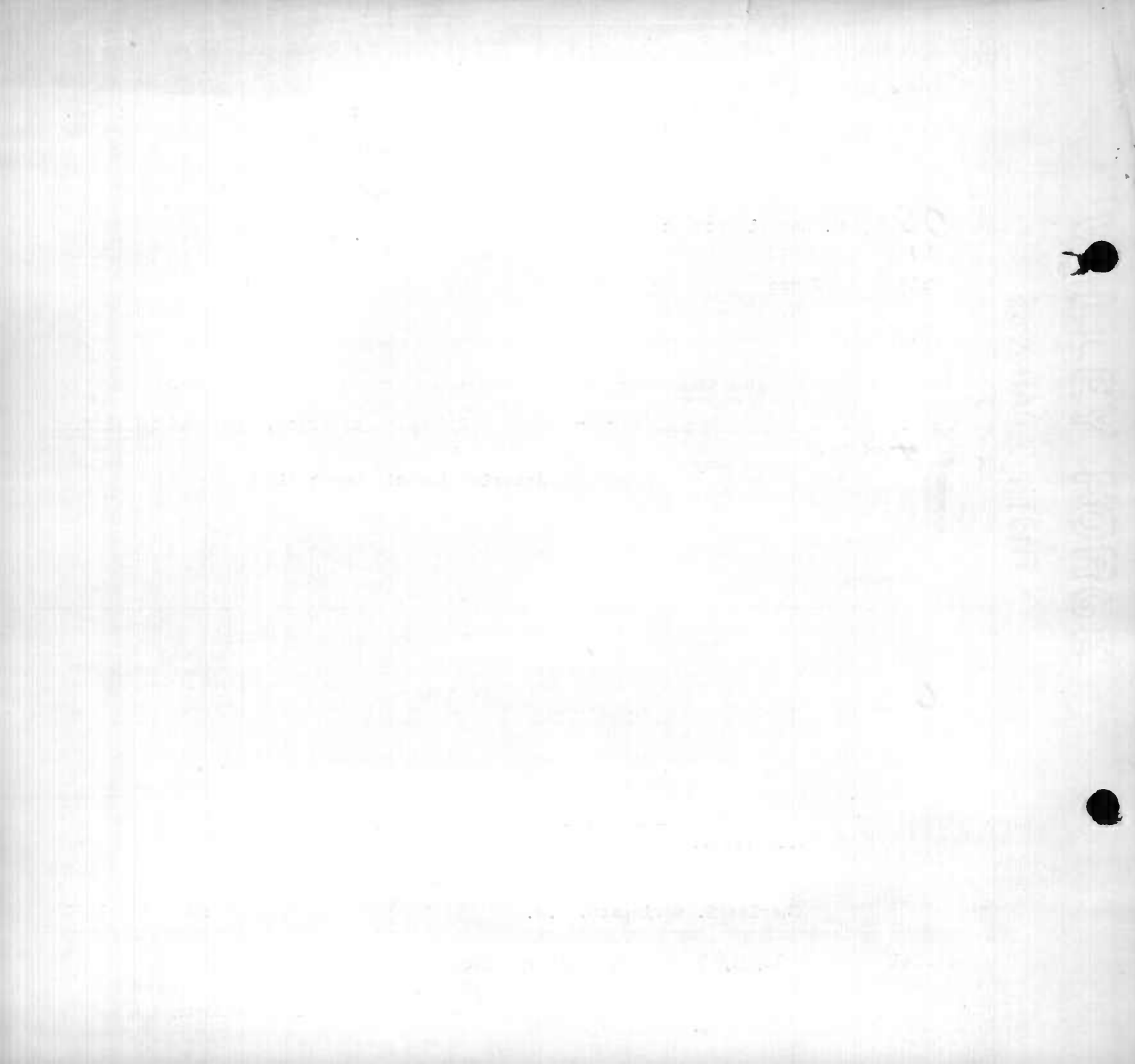
24C. FUNERAL DIRECTOR

ADDRESS

OCT 31 1967

R. E. F. F. F.

A Halstead 1206 W North Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|------------------------------------|---|---|
| BIRTH NO.
67 10346 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10346 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) KENNARD MRS FRANCES | | 2. DATE AND HOUR OF DEATH
10. 30. 67 12-30A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
CERTIFICATE AMENDED
FULL NAME OF HOSPITAL OR INSTITUTION
35 Church Home and Hospital Baltimore MD-21231. | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND. B. COUNTY Balt. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE. 53-00
D. STREET ADDRESS (If rural, give location) 7932 Lansdale Road (34) | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married. | 8. DATE OF BIRTH
1-28-20 | 9. AGE (In years lost birthday)
47 | 10. Under 1 Tr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
AMERICA. | | 13. FATHER'S NAME
Joseph Grzegorzynski | | 14. MOTHER'S MAIDEN NAME
Constance Milanicz | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
212-087219- | | 17. INFORMANT ADDRESS
JOHN H. KENNARD - 7932 LANSDALE RD | |
| 18. 174 X1 SS#212-07-3495
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Terminal Carcinoma
Primary CA in Uterus. | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
1 1/2 mths.
1 1/2 yrs. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
9. 3. 67. | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Obstruction of Small bowel. | | 20A. AUTOPSY? (Yes or No)
No. | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-3-1967 to 10-30-1967 , that (I) (we) last saw the deceased alive on 10-30-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Jose G. City | | | | 23B. DATE SIGNED
10/31/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
11/2/67 | | 24C. NAME of CEMETERY or CREMATORY
ST. STANISLAUS | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE MD | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | | |
| 25B. NAME OF REGISTRAR
John H. Kennard | | 25C. FUNERAL DIRECTOR ADDRESS
ULLRICH FUNERAL HOME DUNDALK MD | | | |

V.S. 153

11-13-67

M.H.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10347

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

KENNETH BOWEN

2. DATE AND HOUR PRONOUNCED DEAD

October 29, 1967 2:10 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

South Baltimore Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1623 Webster Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

16 Jan. 1922

9. AGE (In years
lost birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Morgan Millwork

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Raymond Bowen

14. MOTHER'S MAIDEN NAME

Norma E. Norfolk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL
SECURITY NO.

215-12-3408

17. INFORMANT

ADDRESS

Mrs. Virginia F. Bowen, 1623 Webster St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A)

Arteriosclerotic Cardiovascular
Disease~~XXXXXX~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

Edward F. Wilson

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Nov. 2, 1967

23C. NAME of CEMETERY or CREMATORY

Balto. National Cemetery

23D. LOCATION

(City, town, or county)

(State)

5501 Frederick Ave., Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

OCT 31 1967

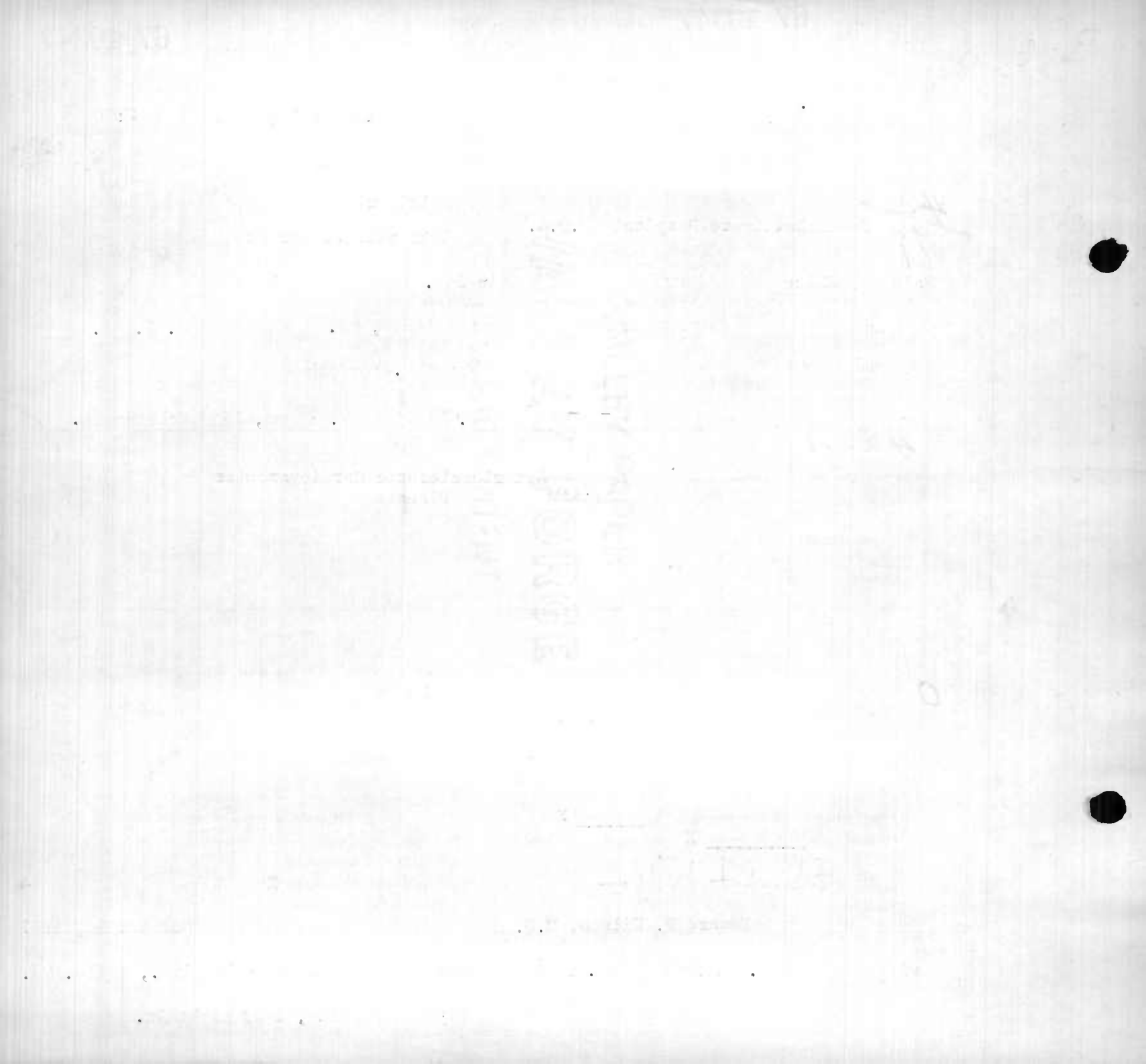
24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

ADDRESS

Flynn & Fleming, 1422 Light St.

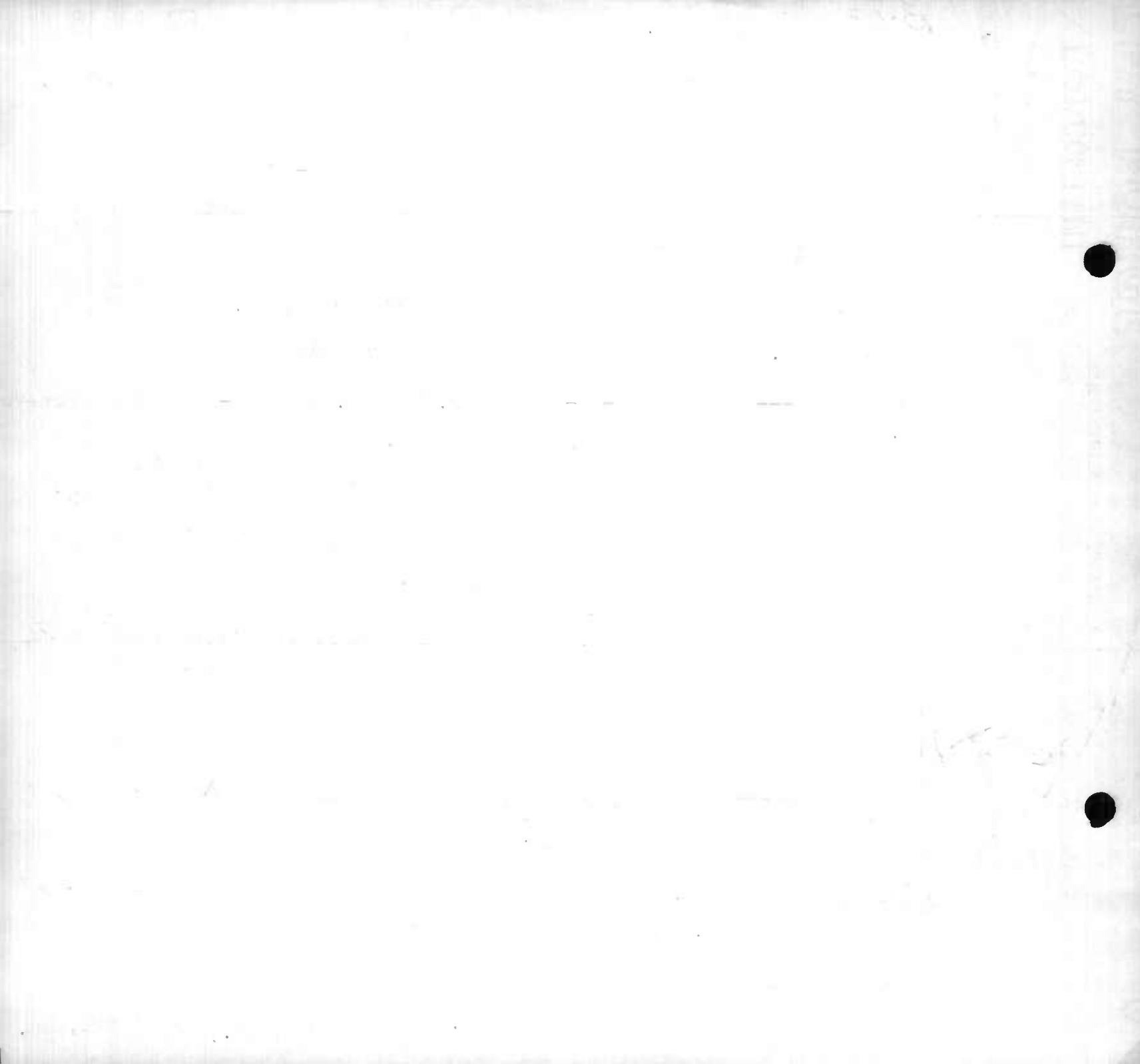


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| BIRTH NO. B-631 | | 67 10348 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10348 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) AGNES SARAH BRADBURN | | | |
| 2. DATE AND HOUR OF DEATH
October 28, 1967 5:00 A.M. | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

00 | | (If not in hospital or institution, give street address or location)
3619 Dudley Avenue | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore - 21213 | |
| D. STREET ADDRESS (If rural, give location)
3619 Dudley Avenue | | 5. SEX
Female | | 6. RACE
White | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | |
| 8. DATE OF BIRTH
March 18, 1874 | | 9. AGE (In years last birthday)
93 | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
at Home | |
| 11. BIRTHPLACE (State or foreign country)
Calvert County, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
John T. Gott | | 14. MOTHER'S MAIDEN NAME
Isabelle Boyd | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-54-1350J1 | | 17. INFORMANT ADDRESS
Mr. James W. Bradburn-1713 Windemere Ave | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
II | | CAUSE OF DEATH
*Rheumatoid arthritis
(A) DUE TO
advanced, Progressive, gen
(B) DUE TO
Arteriosclerotic Heart Disease
(C) Hypertensive C.V.D. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Status pneumonia & gen laryngitis | | 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1 to Oct 28 19 67 , that (I) (we) last saw the deceased alive on Oct 26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 23A. SIGNATURE
Donald W. Mintzer | | 23B. DATE SIGNED
Oct 29 1967 | | 23C. PHYSICIAN'S NAME (Type)
Donald W. Mintzer | |
| 23D. ADDRESS
3009 Evergreen Avenue | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/31/67 | | 24C. NAME OF CEMETERY or CREMATORY
Woodlawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | 25B. NAME OF REGISTRAR
Robert E. Sander | | 25C. FUNERAL DIRECTOR ADDRESS
H. Sander & Sons, Inc., Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10349 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10349 | |
|---|--------------|---|-----------------------------------|--|----------------------------|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | CATHERINE DIEHL | | OCTOBER 28, 1967 9:30 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

00 3031 Eastern Avenue | | | | A. STATE
MARYLAND | | B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE 21224 1-02 | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 3031 Eastern Avenue | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
Dec. 28, 1887 | 9. AGE (In years lost birthday)
79 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Seamstress | | 10B. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (State or foreign country)
Illinois | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Henry Diehl | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Meister | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
212 07 6434 | | 17. INFORMANT
Mr Charles M. Diehl | | ADDRESS
3031 Eastern Ave. | |
| 18. 4-2-11
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <i>Arterio-sclerotic cardio-vascular</i>
DUE TO
(B) <i>disease</i>
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Anemia - type microcytic</i> | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>13 October</i> 19 <i>67</i> to <i>28 October</i> 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>28 October</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>John A. Barnaby</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/30/67 | |
| 23C. PHYSICIAN'S NAME (Type)
John A. Barnaby | | | | 23D. ADDRESS
M.D. 1531 East North Avenue | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/1/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | 25B. NAME OF REGISTRAR
<i>R. E. Farber</i> | | 25C. FUNERAL DIRECTOR
HENRY SANDER & SONS INC. | | ADDRESS | |
| BALTIMORE MARYLAND | | | | | | | |

1875

1875

1875

1875

1875

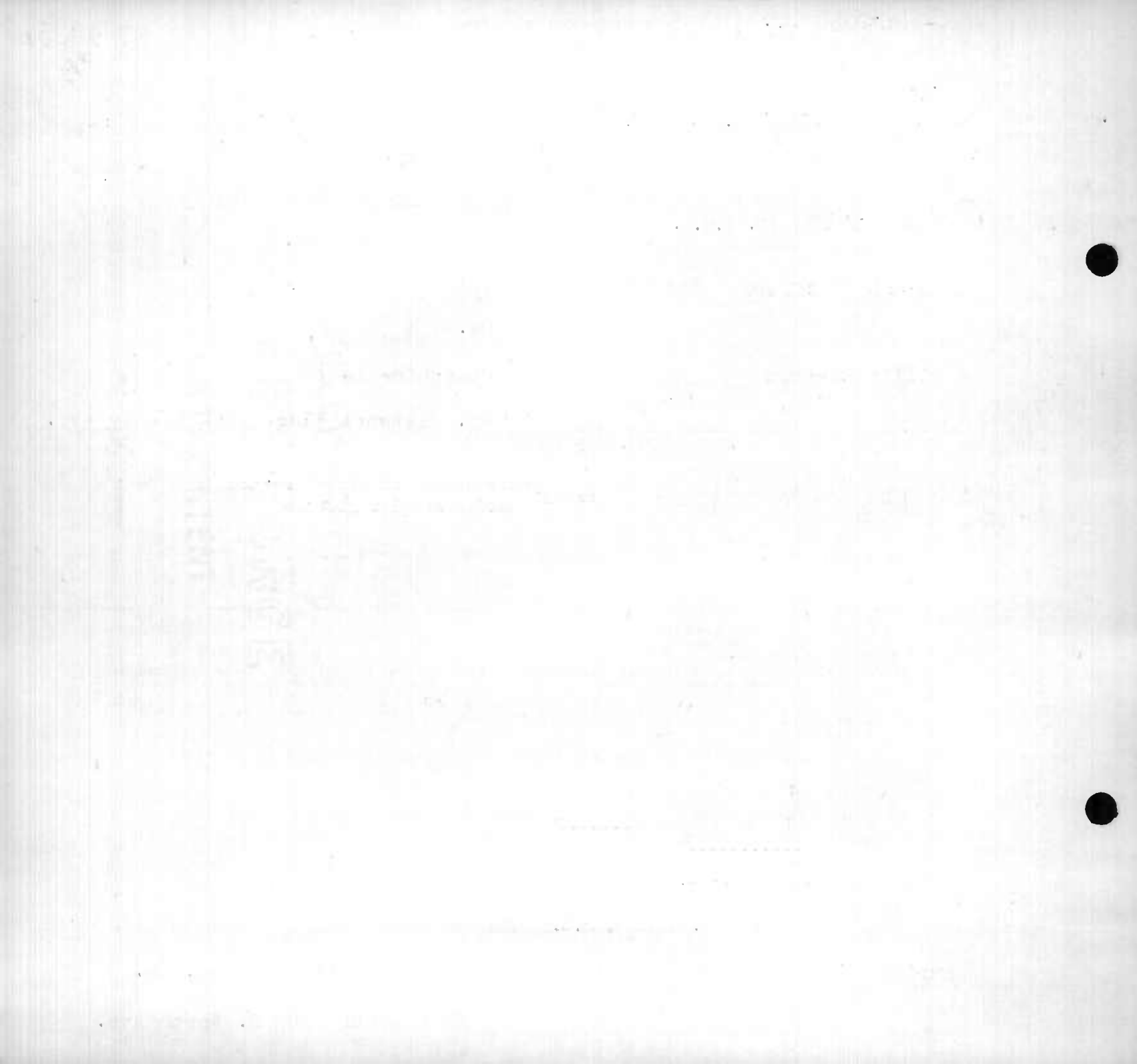
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------|--|---|--|--|
| BIRTH NO. G-426 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10350 | |
| M.E. CASE NO. | | 67 10350 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| GEORGE AUGUST GLASER | | | Oct 28 1967 6:35 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| 90 House in the Pines
5837 Belair Road | | | Maryland | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | D. STREET ADDRESS (If rural, give location) | | |
| Baltimore - 21218 | | | 724 E. 36th Street | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
lost birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Male | White | Widower | Jan. 21, 1882 | 85 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Sup. Postal Dept. | | Retired | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Edward Glaser | | | USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| No --- | | | 216-34-7693 | | Mr. Wm. Miller - |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| 422.11 | | | (A) Enteric shock C. VD | | |
| ANTECEDENT CAUSES | | | (B) DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) | | |
| II | | | Prostatic hypertrophy | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| <input type="checkbox"/> | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1960 to Oct 28 1967, that (I) (we) last saw the deceased alive on Oct 27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| J. Henry Haase | | | | 10/30/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| J. Henry Haase | | | | 2926 E. Coldspring Lane | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 10/31/67 | | Moreland Memorial Park | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| OCT 31 1967 | | O. A. E. F. D. M. | | H. Sander & Sons, Inc., Baltimore, Md. | |

| BIRTH NO. | | 67 10351 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. 67 10351 | |
|--|---------------------------|--|------------------------------------|--|---|--|------------------------------|-------------------------|--|
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
CHERRY A. ELDER | | | | | 2. DATE AND HOUR PRONOUNCED DEAD
October 29, 1967 7:45 p.m. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1406½ Laurens St. D.O.A. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3608 Duvall Ave. | | | | |
| 5. SEX
Female | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
4/14/99 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Ga. | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME
Willie Edwards | | | | | 14. MOTHER'S MAIDEN NAME
Josephine Labon | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mr. Clarence Elder 4560 Finney Ave. | | | | |
| 18. 443X CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Hypertensive Arteriosclerotic Cardiovascular Disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Edward F. Wilson | | EXAMINER'S NAME (Type)
Edward F. Wilson, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
October 30, 1967 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
11/5/67 | | 23C. NAME of CEMETERY or CREMATORY
XXX Anthens, Ga. | | 23D. LOCATION (City, town, or county) (State) | | | |
| 24A. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | 24B. NAME OF REGISTRAR
Robert E. Fairley, M.D. | | 24C. FUNERAL DIRECTOR
Wm C March | | ADDRESS
928 E. North Ave. | | | |

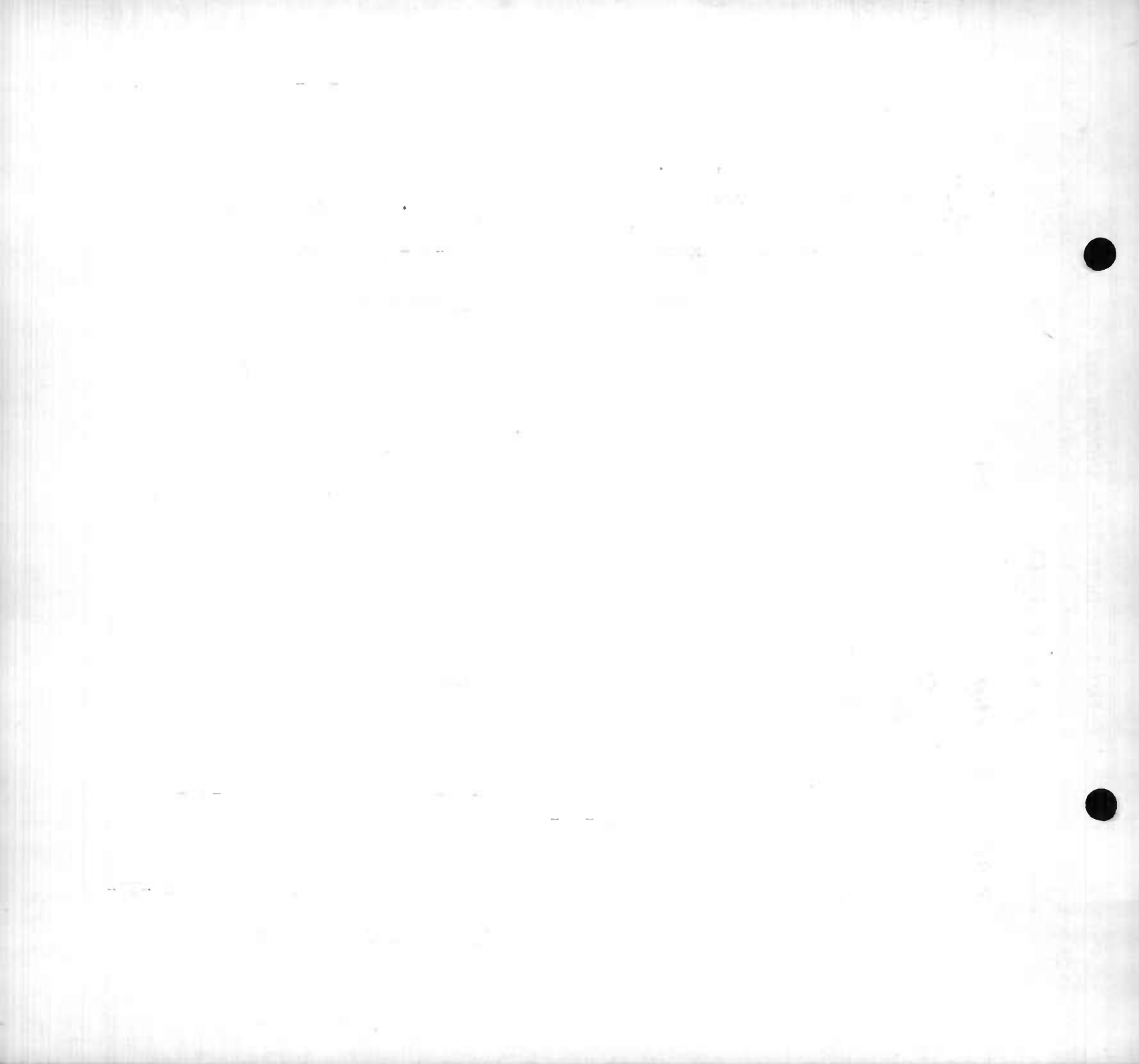


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|---|-------------------------------------|--|---|
| J-520 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10352 | |
| BIRTH NO. 67 10352 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>William Jones</i> | | 2. DATE AND HOUR OF DEATH
10-28-67 4:40 a. m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>Provident Hospital, Inc.
1514 Division Street</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i>
D. STREET ADDRESS (If rural, give location)
<i>613 W. Mulberry Street</i> | | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>Negro</i> | 7. MARRIED, NEVER MARRIED
<i>Married</i> | 8. DATE OF BIRTH
<i>11-26-23</i> | 9. AGE (In years last birthday)
<i>43</i> | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Laborer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Unemployed</i> | | 11. BIRTHPLACE (State or foreign country)
<i>North Carolina</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 13. FATHER'S NAME
<i>Will Jones</i> | | 14. MOTHER'S MAIDEN NAME
<i>Patient Jones</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<i>CARRIE JOHNSON 722 W. LEXINGTON</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>156.11</i>
<i>Carcinoma of the Liver</i> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-23-67</i> 19 to <i>10-28-67</i> 19, that (I) (we) last saw the deceased alive on <i>10-28-67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Gregorio S. Tengco</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>10-31-67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>GREGORIO S. TENGCO</i> | | 23D. ADDRESS
M.D. <i>1514 Division Street</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | 24B. DATE
<i>10/1/67</i> | 24C. NAME of CEMETERY or CREMATORY
<i>Mt. Calvary Cem.</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Anne Arundel City, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 31 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>WM. MARCH 928 E. North Ave</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------------|---|-----------------------------------|--|---|--|--|
| BIRTH NO. D-140 | | 67 10353 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10353 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) SUSIE DUNNALL | | | | 2. DATE AND HOUR OF DEATH
6:35 AM 11/28/67 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Johns Hopkins Hospital | | (If not in hospital or institution, give street address or location) | | A. STATE
MD | | B. COUNTY
9.9.6 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Annapolis 32-10 | | | |
| 33 | | | | D. STREET ADDRESS (If rural, give location)
2049 Bestgate Dr. | | | |
| 5. SEX
F | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
4-4-07 | 9. AGE (In years last birthday)
60 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
March | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MD | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Samuel Parker | | | | 14. MOTHER'S MAIDEN NAME
SUSIE YOUNG | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
21336317 | | 17. INFORMANT
Sadie Thompson | | ADDRESS
Annapolis | |
| 18. 172 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) Carcinoma in
DUE TO
(B) Adeno Squamous CA of Endometrium?
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
2 mo.
14 mo. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
9/23/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Abdominal mass | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | | 21C. WHERE DID INJURY OCCUR?
— | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/15 19 67 to 10/28 19 67 , that (I) (we) last saw the deceased alive on 10/28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="radio"/> (I) <input checked="" type="radio"/> (We) <input type="radio"/> (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Oscar Hume | | | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/24/67 | |
| 23C. PHYSICIAN'S NAME (Type)
O. SCOTT Hume | | 23D. ADDRESS
Johns Hopkins Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-1-1967 | | 24C. NAME OF CEMETERY or CREMATORY
Adams | | 24D. LOCATION (City, town, or county) (State)
Lothian MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
William Reese | | ADDRESS
Annapolis | |

Samuel Parker
Zoe Young

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Non-Medical Released for the Medical Examiners Office by: Dr. Linthicum per Mr. Mason

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO.
67 10354 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10354 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print)
Ernest A. Doles | | | 2. DATE AND HOUR OF DEATH
10-30-67 2:00P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
The Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | |
| 5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | | | 8. DATE OF BIRTH 9-20-34 9. AGE (In years last birthday) 33 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chaffeur | | | 11. BIRTHPLACE (State or foreign country) Maryland | | |
| 13. FATHER'S NAME Thomas Doles | | | 14. MOTHER'S MAIDEN NAME Hilda Williams | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES | | | 16. SOCIAL SECURITY NO. 28-28-5289 | | |
| 17. INFORMANT Hilda Doles ADDRESS Seneca | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 18. 154X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) Cachexia - several weeks
DUE TO
(B) metastasis + local growth of ca - several months
DUE TO
(C) Carcinoma of rectum 2 years + longer + familial polyposis | | |
| 19A. DATE OF OPERATION 9/13/66 + 9/18/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED polyps in rectum + sigmoid | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE | |
| 21D. TIME OF INJURY (APPROX.) NONE | | 21E. INJURY OCCURRED While At <input checked="" type="checkbox"/> 0 Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? 0 | |
| 22. I certify that (1) (this hospital) attended the deceased from early 19 66 to 10/30 19 67 , that (1) (we) last saw the deceased alive on 10/30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Bertram Zarins, M.D. | | | | 23B. DATE SIGNED 10/30/67 | |
| 23C. PHYSICIAN'S NAME (Type) BERTRAM ZARINS | | | | 23D. ADDRESS Johns Hopkins Hospital, Balto, Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burne | | 24B. DATE 11-8-67 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Mt | |
| 25A. DATE REC'D BY HEALTH DEPT. OCT 31 1967 | | 25B. NAME OF REGISTRAR R. E. Johnson | | 25C. FUNERAL DIRECTOR Wm. Wilson | |
| | | | | ADDRESS over Bunting St | |

10-10-18

10-10-18

10-10-18

10-10-18 10-10-18 10-10-18

10-10-18

10-10-18 10-10-18 10-10-18

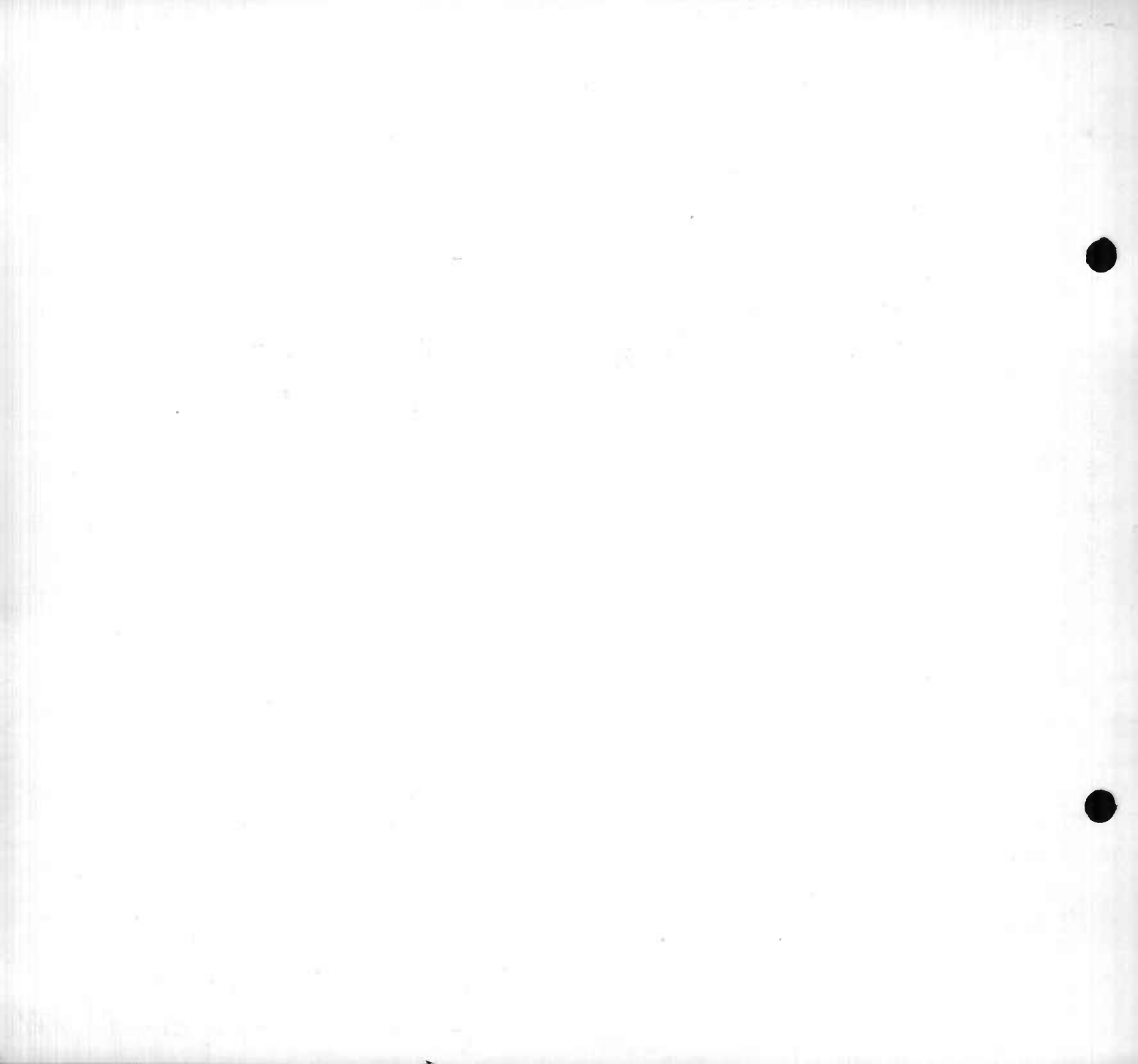
10-10-18

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------------|--|------------------------------------|--|--|
| BIRTH NO. <u>m-252 67 10355</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>67 10355</u> | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>McNISH, SUSAN D.</u> | | 2. DATE AND HOUR OF DEATH
<u>10-29-67</u> <u>2⁰⁵</u> P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION <u>31 BALTIMORE CITY HOSPITALS</u>
<u>4940 EASTERN AVENUE</u>
<u>BALTIMORE 21224, MARYLAND</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>BALTIMORE</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>
D. STREET ADDRESS (If rural, give location) <u>26-12 BALTIMORE CITY HOSPITALS</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
<u>WIDOW</u> | 8. DATE OF BIRTH
<u>2-18-87</u> | 9. AGE (in years last birthday)
<u>80</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>TENNESSEE</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>Pleasant Dixon</u> | | 14. MOTHER'S MAIDEN NAME
<u>Margaret</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>21224, MARYLAND</u>
<u>RECORDS: BCH 4940 EASTERN AVE. BALTIMORE</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>331X I</u>
<u>CAUSE OF DEATH</u>
<u>Cerebrovascular Accident unknown</u> | | 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>HCVD</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-26-64</u> 19 to <u>10-29</u> 19 <u>67</u> . that (I) (we) last saw the deceased alive on <u>10-29</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Raymond J. LaSue</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>10-29-67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>DR. RAYMOND J. LA SUE</u> | | 23D. ADDRESS
<u>BALTIMORE 21224, MARYLAND</u>
<u>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>11/1/67</u> | 24C. NAME OF CEMETERY or CREMATORY
<u>Perrins Hollow Cem</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Blaine, Tenn.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>OCT 31 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fisher, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>James M. Fields, Balto., Md.</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|-------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10356 | |
| BIRTH NO. 67 10356 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH
October 30, 1967 1 8:30 P.M. | |
| 1. NAME OF DECEASED
(Type or Print) Homer E. Scovern | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore Co. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Gould Convalesarium
6116 Belair Road | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Raspesburg 33-00 | |
| | | D. STREET ADDRESS (If rural, give location)
4213 Kenwood Ave. #06 | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
9/2/1877 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired salesman | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
90 |
| 11. BIRTHPLACE (State or foreign country)
Illinois | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William H Scovern | | 14. MOTHER'S MAIDEN NAME
Anna ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs Eloise Ernest | | ADDRESS
4213 Kenwood Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH
3 hrs | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

Generalized Arteriosclerosis severe | | (B) DUE TO
20 yrs | |
| (C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the physician) attended the deceased from Oct 1 1967 to 30 Oct 1967 , that (I) (the last saw the deceased alive on 19 Oct 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Joseph F. LiPira | | 23B. DATE SIGNED
10/31/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Joseph F. LiPira | | 23D. ADDRESS
8400 Loch Raven Blvd. Balt. H. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
burial | | 24B. DATE | |
| 24C. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | |
| 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc | | ADDRESS
Baltimore, Md. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10357 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 10357 | |
|---|-------------------------|---|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) <i>M. Elizabeth Gross</i> | | | | 2. DATE AND HOUR OF DEATH
<i>10/28/67</i> <i>8:40</i> P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
<i>Jenkins Memorial Hospital</i>
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>91 Jenkins Memorial Hosp.</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>66-00</i>
D. STREET ADDRESS (If rural, give location) <i>7409 Juneau Street, Washington, D.C.</i> | | | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widowed</i> | | B. DATE OF BIRTH
<i>9/2/85</i> | 9. AGE (In years last birthday)
<i>82</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>John Schiefer</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Amelia Ebling</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | 16. SOCIAL SECURITY NO.
<i>220-46-2369</i> | | 17. INFORMANT ADDRESS
<i>Hospital Records 1000 S. Caton Ave.</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<i>II</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) <i>Acute coronary occlusion</i>
DUE TO <i>minutes</i> | | | | | |
| | | | | (B) <i>Arteriosclerotic Heart Disease</i>
DUE TO <i>years</i> | | | | | |
| | | | | (C) <i>cerebral vascular insuff.</i>
<i>fracture humerus, left</i>
<i>years</i>
<i>12 days</i> | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<i>Hospital</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<i>1000 Caton Ave. Jenkins Memorial Hosp., Bg 10, Md.</i> | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
<i>Oct 10 67 5:45 PM</i> | | | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<i>slipped in corridor and hit over</i> | | | | | | | |
| 22. I certify that (A) (this hospital) attended the deceased from <i>10/28</i> 19 <i>67</i> and that in (B) (my) opinion death occurred on the date and hour and from the causes stated above. (C) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23. SIGNATURE
<i>J. Raymond Gladue</i>
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED
<i>10/28/67</i> | | | | | |
| 24. PHYSICIAN'S NAME (Type)
<i>J. Raymond Gladue</i> | | | | 23D. ADDRESS
<i>Jenkins Memorial Hospital</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11/2/67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Holy Redeemer Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 31 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fisher</i> | | 25C. FUNERAL DIRECTOR
<i>Leonard J. Ruck, Inc.</i> | | 25D. ADDRESS
<i>Balto. Md. 21214</i> | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10358 |
|--|--------------------------------|--|---|--|
| BIRTH NO. 67 10358 | | CERTIFICATE OF DEATH | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) CHARLES H CHARLIE SCHADIE | | 2. DATE AND HOUR OF DEATH
10/27/67 5:45 P M. |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
33 THE JOHNS HOPKINS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND, BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) WHITE MARSH 21162
D. STREET ADDRESS (If rural, give location) 53-00 RED LINE ROAD | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
3-27-1884 | 9. AGE (In years last birthday) 83 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY
Harry T. Campbell | 11. BIRTHPLACE (State or foreign country)
Baltimore, Co. Maryland | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Schadie | | 14. MOTHER'S MAIDEN NAME
Elizabeth | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218071685 | 17. INFORMANT ADDRESS
Mrs Viola M. Schultz Red Lion Road | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Myocardial Infarction
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ACSCVD
Swiss Arteriosclerosis | | CAUSE OF DEATH
INTERVAL BETWEEN ONSET AND DEATH
1 Day | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic Lung Disease | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/26 19 67 to 10/27 19 67 , that (I) (we) last saw the deceased alive on 10/27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Henry R. Black | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | 23B. DATE SIGNED
10/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
HENRY R. BLACK | | 23D. ADDRESS
Johns Hopkins Hosp | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
10-31-1967 | 24C. NAME of CEMETERY or CREMATORY
Camp Chapel Cemetery | 24D. LOCATION (City, town, or county) (State)
Baltimore Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairbank | 25C. FUNERAL DIRECTOR ADDRESS
Lessahart Funeral Home 7401 Belair Rd | |



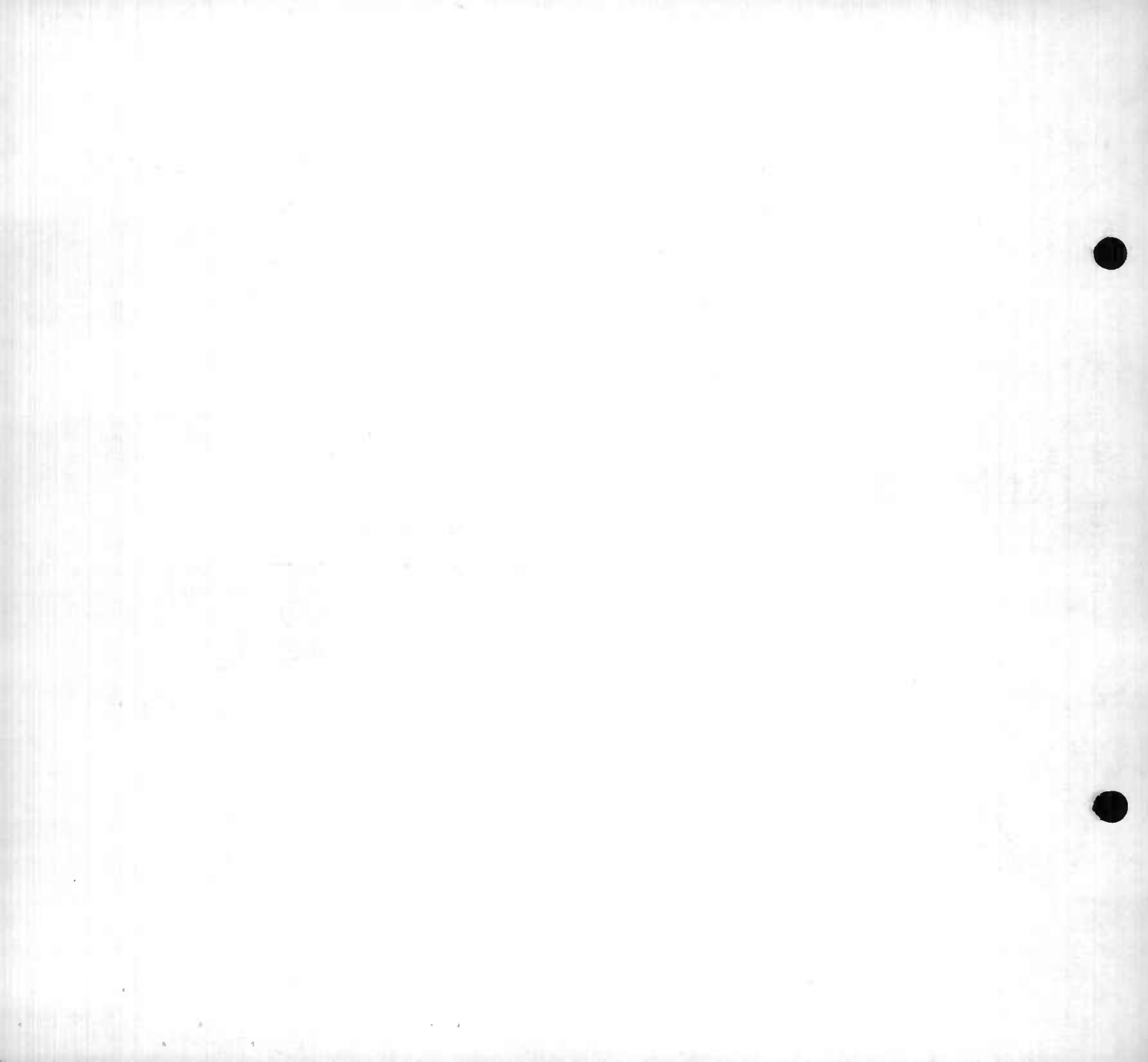
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10359 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. 67 10359 | |
|--|-------------------------|--|-------------------------------------|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>James F Taylor</i> | | | | 2. DATE AND HOUR OF DEATH
<i>10-29-67 8:30 PM</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>Maryland Gen. Hosp.</i>
<i>48</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore Md. 21212</i>
D. STREET ADDRESS (If rural, give location)
<i>5910 Backenridge Rd.</i> | | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>white</i> | 7. MARRIED, NEVER MARRIED
(WIDOWED) DIVORCED (specify)
<i>WIDOWED</i> | 8. DATE OF BIRTH
<i>07-23-91</i> | 9. AGE (In years last birthday)
<i>76</i> | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Pennsylvania Railroad</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Thomas Taylor</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Mary Ann Brown</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Yes WWI</i> | | 16. SOCIAL SECURITY NO.
<i>717-07-6431</i> | | 17. INFORMANT
<i>Daughter-in-law - Mary Lee Taylor</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
<i>PNEUMONIA, Hemorrhagic, Bacterial</i>
<i>Arteriosclerotic Cerebrovascular Disease</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-21-67</i> to <i>10-29-1967</i> , that (I) (we) last saw the deceased alive on <i>10-29-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Cyrus Makoni</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>10-29-67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Cyrus Makoni</i> | | | | 23D. ADDRESS
<i>Maryland Gen. Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11/2/67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>New Cathedral</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 31 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR & ADDRESS
<i>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</i> | | | |



RELEASED AS NON-MED BY DR. WILSON
PER MR. GREGORY OF M.B. OFFICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|------------------------------------|--|--|
| BIRTH NO. 67 10360 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10360 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Louis B. Peters</i> | | 2. DATE AND HOUR OF DEATH
<i>10-27-67 8:20 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>Johns Hopkins Hospital</i>
<i>33</i> | | D. STREET ADDRESS (If rural, give location)
<i>6002 Kent Club Lane</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>11-20-1912</i> | 9. AGE (In years last birthday) <i>54</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>CPA-LAWYER</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>LEGAL</i> | | 11. BIRTHPLACE (State or foreign country)
<i>N.J.</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>PETERS</i> | | 14. MOTHER'S MAIDEN NAME
<i>Vasiliky Brivikis</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service)
<i>Yes W.W.II</i> | | 16. SOCIAL SECURITY NO.
<i>240-24-9535</i> | | 17. INFORMANT
<i>CONSTANCE C. PETERS ABOVE</i> | |
| 18. <i>420.1 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) <i>MI</i>
DUE TO
(B) <i>coronary artery disease</i>
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <i>she</i> (this hospital) attended the deceased from <i>10/21</i> to <i>10/24</i> 19 <i>67</i> .
that <i>she</i> (we) last saw the deceased alive on <i>10/24</i> 19 <i>67</i> and that in (my) <i>my</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>did</i> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Monica M Buckley</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>10/27/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Monica M. Buckley</i> | | 23D. ADDRESS
<i>The Johns Hopkins Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>10/30/1967</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Druid Ridge</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Pikesville, Balto. Co., Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>OCT 31 1967</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR
<i>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</i> | | | |

[illegible]

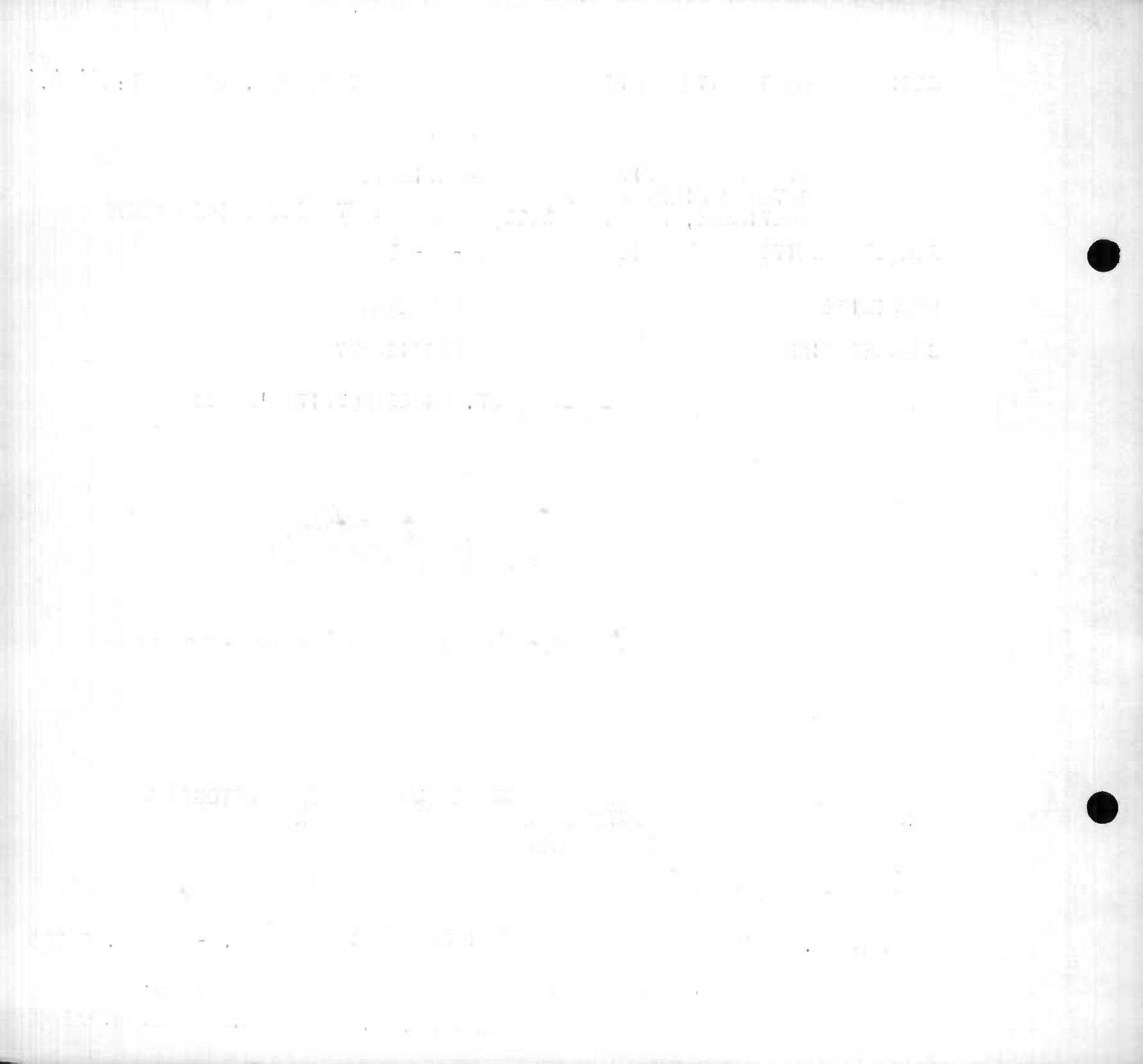
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|------------------|--|--|--|--|--|-------------------------------------|
| BIRTH NO. | | 67 10361 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10361 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) COLLETT, ELLA R | | | | 2. DATE AND HOUR OF DEATH
OCTOBER 29, 1967 2:45 A. M. E.S.T. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
40 ST AGNES HOSPITAL
CATON & WILKENS AVENUES
BALTIMORE, MARYLAND 21229 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 21228 21212 27-48
D. STREET ADDRESS (If rural, give location)
315 SHADY NOOK 1014 Witherspoon Rd. | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
DIVORCED | 8. DATE OF BIRTH
10-05-86 | 9. AGE (In years lost birthday)
81 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired School Teacher | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
CLARK STALNAKER | | | 14. MOTHER'S MAIDEN NAME
ELIZABETH DODDRILL | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
213-48-3210 | | 17. INFORMANT ADDRESS
ST. AGNES HOSPITAL'S RECORD | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
331X1
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) DUE TO
CVA - Cerebrovascular
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
minutes | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from OCTOBER 21 19 67 to OCTOBER 29 19 67, that (X) (we) last saw the deceased alive on OCTOBER 29 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
ANGOVGE DYER M.D. | | | | | | 23B. DATE SIGNED
10/29/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
CATON & WILKENS AVES. - BALTO. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/31/67 | | 24C. NAME OF CEMETERY or CREMATORY
Gardens of Faith Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. | | ADDRESS
Balto. Md. 21214 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

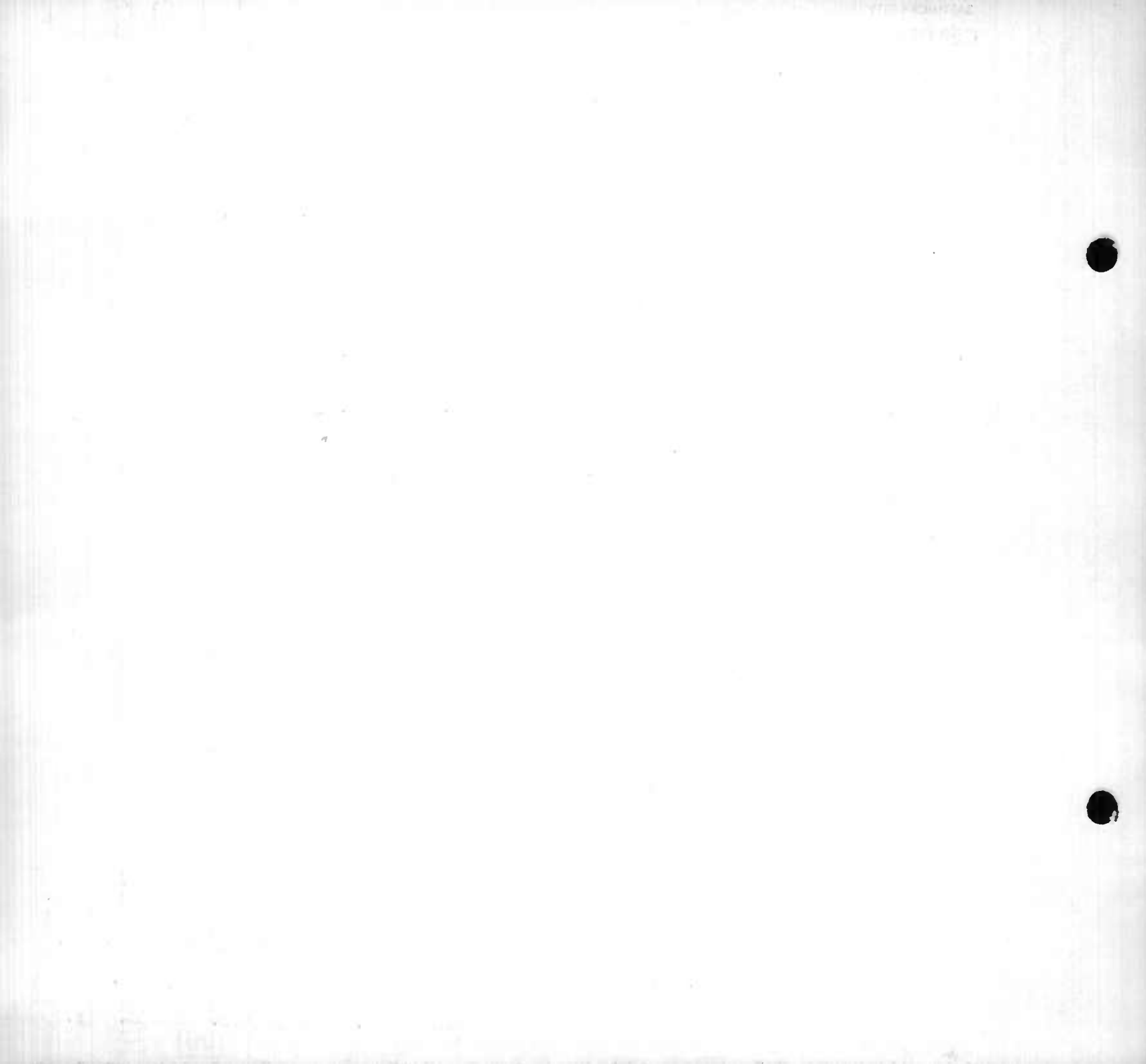
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|--|---|--|--|--|-----------------------------|--|
| 67 10362 CERTIFICATE OF DEATH | | | | | Registered No. 67 10362 | | | | |
| BIRTH NO. 67 10362 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) KLEIN MARGARUITE MARIE | | | | | 2. DATE AND HOUR OF DEATH
OCTOBER 29, 1967 2:00 A.M. E.S.T. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
40 ST AGNES HOSPITAL CATON & WILKENS AVES BALTIMORE, MARYLAND 21229 | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
1907 EAST BELEVADERE AVENUE | | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
MARRIED | | 8. DATE OF BIRTH
09-02-02 | 9. AGE (In years last birthday)
65 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
CHARLES FINK | | | | | 14. MOTHER'S MAIDEN NAME
MAGGIE OTTO | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
216-05-1617 | | 17. INFORMANT ADDRESS
ST. AGNES HOSPITAL'S RECORD | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Chemia | | | | | INTERVAL BETWEEN ONSET AND DEATH
date admitted 10-20-67 - 10-29-67 | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Constriction of utero-pelvic junction & pyelonephrosis. Left Kidney. | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Toxic hepatitis from septicemia - organism to be determined | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCTOBER 24 19 67 to OCTOBER 29 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on OCTOBER 29 19 67 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Carl H. Matthey | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10-29-1967 | | |
| 23C. PHYSICIAN'S NAME (Type)
CARL H. MATTHEY | | | | | 23D. ADDRESS
M.D. WILKENS & CATON AVES. - BALTO. 21229 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/1/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
10-31-1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. | | ADDRESS
Balto. Md. 21214 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 10363</u> | |
|--|---------------------|--|-------------------------------------|--|--|
| BIRTH NO. <u>67 10363</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>HENRY D. FILLING</u> | | 2. DATE AND HOUR OF DEATH
<u>10-28-67</u> <u>1540</u> P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>49 North Charles General Hospital</u> | | A. STATE <u>Md.</u> B. COUNTY <u>Balto. City</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore 21218</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>1730 E. 32nd. Street</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>11-30-97</u> | 9. AGE (In years last birthday)
<u>69</u> | 10. Under 1 Yr. Months: Days: Hours: Min.
<u>9-06</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired - Guard Pinkerton Gds.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Maryland</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>George Filling</u> | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Housman</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>216-09-1626</u> | | 17. INFORMANT
<u>Mrs. Nora P. Filling</u> | |
| 18. <u>154 X I</u> | | CAUSE OF DEATH | | ADDRESS
<u>(Same)</u> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO
<u>CARCINOMA - RECTUM</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 weeks</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
<u>Heart failure</u> | | <u>1 week</u> | |
| (C) _____ | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notably medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Weym, A. J.</u> | | | | 23B. DATE SIGNED
<u>10-28-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
<u>North Charles General Hosp.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>11/1/67</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Loudon Park Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | | 25A. DATE RECEIVED BY HEALTH DEPT.
<u>10/31/67</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | |
| 25C. FUNERAL DIRECTOR
<u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | | 25D. ADDRESS | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10364 | |
|--|--|--|--|--|--|
| 67 10364 CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | Plakotaris | |
| 1. NAME OF DECEASED
(Type or Print) (Emmanuel) | | 2. DATE AND HOUR OF DEATH | | 10/27/67 10 ³⁰ | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE B. COUNTY | | | |
| 110 E. Belvedere Ave. | | 110 E. Belvedere Ave. Apt-2122 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore Md. 27-12 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED NEVER MARRIED | |
| M | | W | | WIDOWED, DIVORCED (specify) | |
| | | | | Married | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| retired (Restaurant Owner) | | | | aug 27 1991 76 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years lost birthday) | |
| Solis Plakotaris | | Chris Guece | | 76 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 232 587283 | | Mrs. Elizabeth Plakotaris | |
| | | | | ADDRESS | |
| | | | | (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 | | that (I) (we) lost saw the deceased alive on 10/14 1967 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| James H. Ceanir MD | | 10/27/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| JAMES H. CIANOS MD | | 3350 WILKENS AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 10/30/67 | | Greek Orthodox Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| OCT 31 1967 | | Robert E. Faldut | | Leonard J. Ruck, Inc. Balto. Md. 21214 | |

J-520

67 10365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 10365

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)(Anna)
Ann^{ie} G. Jones

2. DATE AND HOUR OF DEATH

10/27/67

11256 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)31
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md. Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6305 Elliott St.

21224

5. SEX

White

6. RACE

Female

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

12-23-1886

9. AGE (In years
lost birthday)

80

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Julius Schwarz

14. MOTHER'S MAIDEN NAME

Matilda Thomas

15. Was Deceased Ever in U. S. Armed Forces?

No

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

212-01-1673

17. INFORMANT

ADDRESS

Records: BCM-4940 Eastern Avenue 21224

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

Pneumonia

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B)
DUE TO

Congestive Heart Failure

5 days

(C)
DUE TO

ASCUD

Years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~this hospital~~ attended the deceased from October 24, 1967 to October 27, 1967,
that ~~we~~ last saw the deceased alive on October 27, 1967 and that in ~~my~~ our opinion death occurred on the date
and hour and from the causes stated above. ~~I (we) did (not)~~ view the body after death.

23A. SIGNATURE

Neil R. Williamson

M.D.

Attending ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

10/27/67

23C. PHYSICIAN'S
NAME (Type)

Neil R. Williamson

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

10/30/67.

24C. NAME of CEMETERY or CREMATORY

Immanuel Lutheran Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 31 1967

25B. NAME OF REGISTRAR

Robert E. Fairman

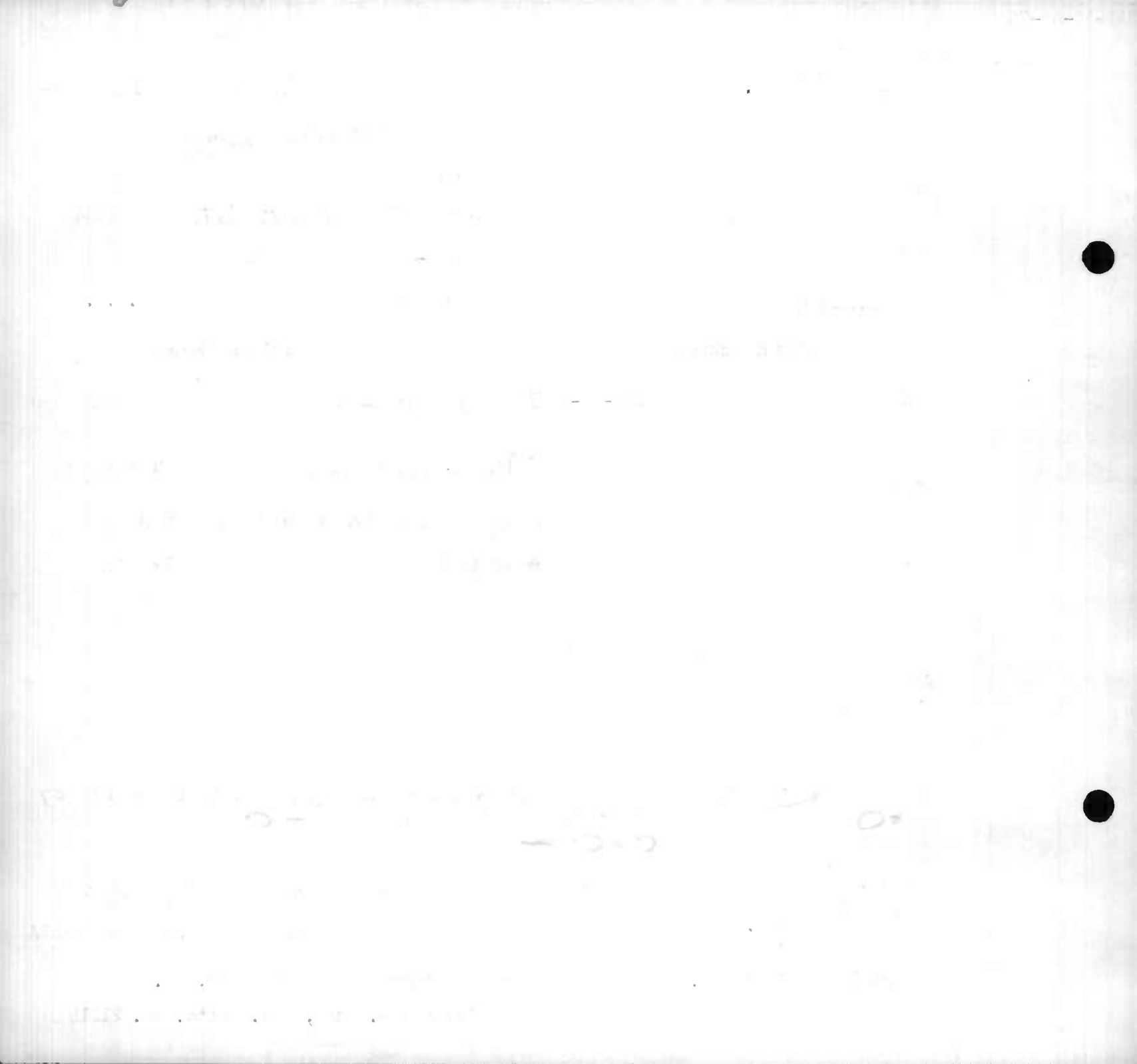
25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10366

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN PFEIFER SR.

2. DATE AND HOUR PRONOUNCED DEAD

October 29, 1967 10:40 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5627 Frankford Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1/14/1903

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sales

10B. KIND OF BUSINESS OR INDUSTRY

Self Employed

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Pfeifer

14. MOTHER'S MAIDEN NAME

Laura Bish

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWI

16. SOCIAL
SECURITY NO.

22003 9910

17. INFORMANT

Mrs. Margaret Pfeifer - Same

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)X (A) Due to
XXArteriosclerotic Cardiovascular
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Edward F. Wilson

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 30, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

11/2/67

23C. NAME OF CEMETERY or CREMATORY

Baltimore Natl. Cem.

23D. LOCATION

(City, town, or county)

Catonsville, Maryland

24A. DATE REC'D BY HEALTH DEPT.

OCT 31 1967

24B. NAME OF REGISTRAR

R. E. F. Wilson

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. 535 Harford Rd.

ADDRESS

ESCALANTE

CLIFF

CLIFF

CLIFF

CLIFF

CLIFF

CLIFF

CLIFF

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CLIFF

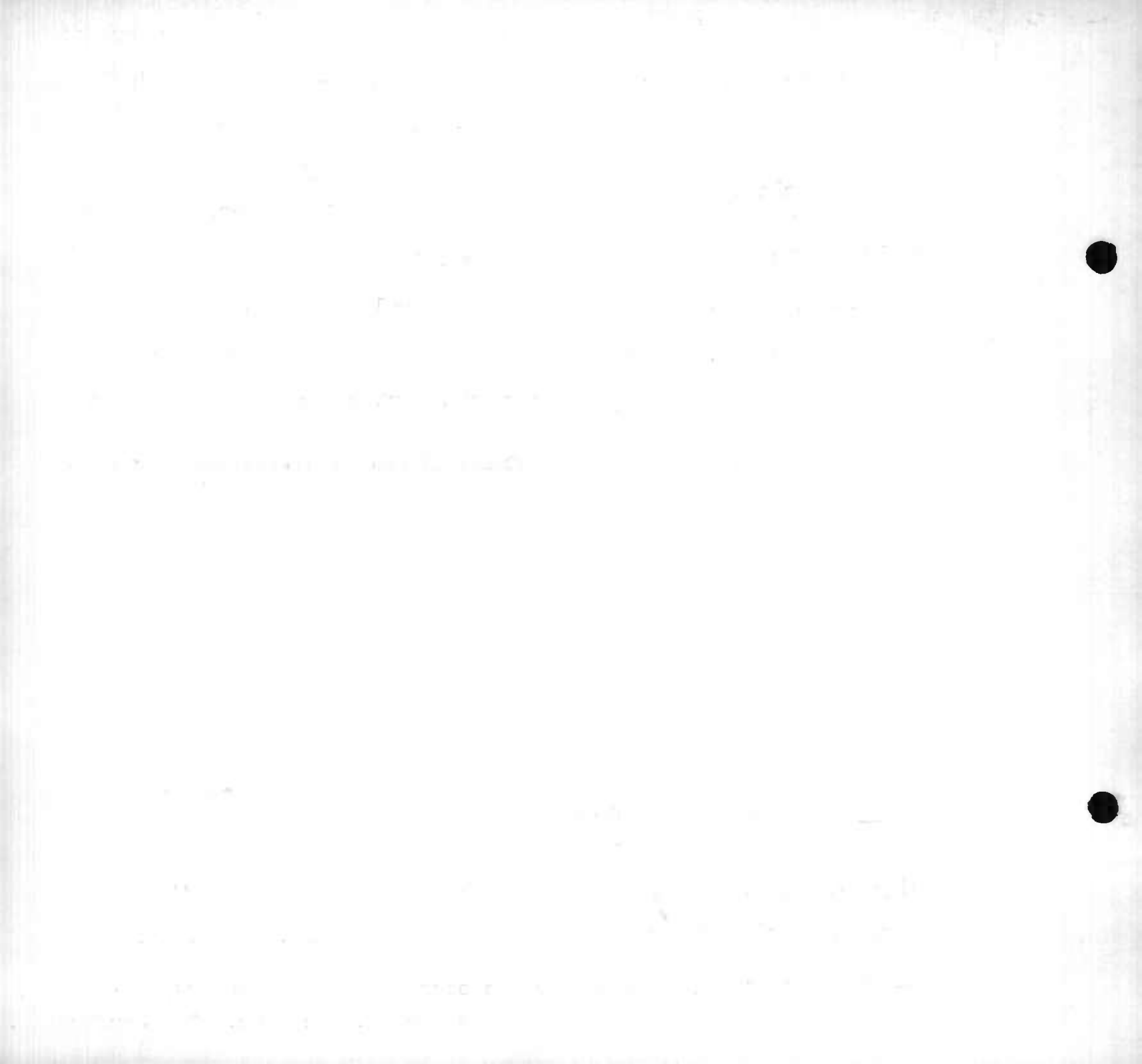
CLIFF

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|--|--|---|
| BIRTH NO.
67 10367 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10367 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) Minnie A. Richards | | | 2. DATE AND HOUR OF DEATH
October 28 1967 1 10 ⁵⁵ A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
90 Gould Convelesarium | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
Maryland Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 21234
D. STREET ADDRESS (If rural, give location)
10013 Harford Road CARNEY, Md. | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Feb. 20, 1888 | 9. AGE (In years last birthday)
79 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Louis T. Bosse | | | 14. MOTHER'S MAIDEN NAME
Alice Swift | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-32-3252 | 17. INFORMANT
Mrs. Myrtle Richards | | ADDRESS
(Same) |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
450.01 Generalized arteriosclerosis
DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH
3 years | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | DUE TO | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1965 to Oct. 28 1967, that (I) was lost saw the deceased alive on Oct 26 19 67 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Donald Jandorf | | | | 23B. DATE SIGNED
10-28-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. R. Donald Jandorf | | | | 23D. ADDRESS
M.D. 6077 Harford Rd., Balto. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/1/67 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
Oct 31 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc. 5305 Harford Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|--|---|--|
| BIRTH NO. 67 10368 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10368 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Florence Pinkerton</i> | | 2. DATE AND HOUR OF DEATH
<i>Oct 29 1967 16:30 P.</i> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i>
B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore 27-01</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>90 House in the Pines Belair Road</i> | | D. STREET ADDRESS (If rural, give location)
<i>Formerly of 3202 Overland Ave.</i> | | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widow</i> | 8. DATE OF BIRTH
<i>June 16, 1892</i> | 9. AGE (In years last birthday)
<i>75</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Home</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 13. FATHER'S NAME
<i>Harry Livingston</i> | | 14. MOTHER'S MAIDEN NAME
<i>Mary ?</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>213481136</i> | | 17. INFORMANT
<i>Mr. John Mansperger- 9828 Forge Park Rd.</i> | |
| 18. <i>1638 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>Carcinoma of Lung</i>
DUE TO
(B)
DUE TO
(C)
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Underlying disease, i.e., cancer</i> | | | | | |
| 19A. DATE OF OPERATION
<i>May 1964</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Cancer of Lung</i> | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12.5 to Oct 29</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Oct 29</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>J. Henry Haase</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>10/29/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>J. Henry Haase M.D.</i> | | 23D. ADDRESS
<i>2920 E. Cal Spring Lane Balto. 14 Md</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11/2/67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Parkwood Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Co., Maryland</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>Oct 31 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Tabor</i> | | 25C. FUNERAL DIRECTOR
<i>Leonard J. Ruck, Inc. Balto. Md. 21214</i> | |

August 10, 1881

Dear Mr. [illegible]

I have the pleasure to inform you that

the [illegible] of the [illegible] is now [illegible]

Very respectfully,
[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10369 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10369 | |
|--|-------------------------------|---|--|--|------------------------------|--|--|
| 1. NAME OF DECEASED
(Type or Print)
Edgar Franklin Carneal | | | | 2. DATE AND HOUR OF DEATH
Oct. 29, 1967 10:30 p M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

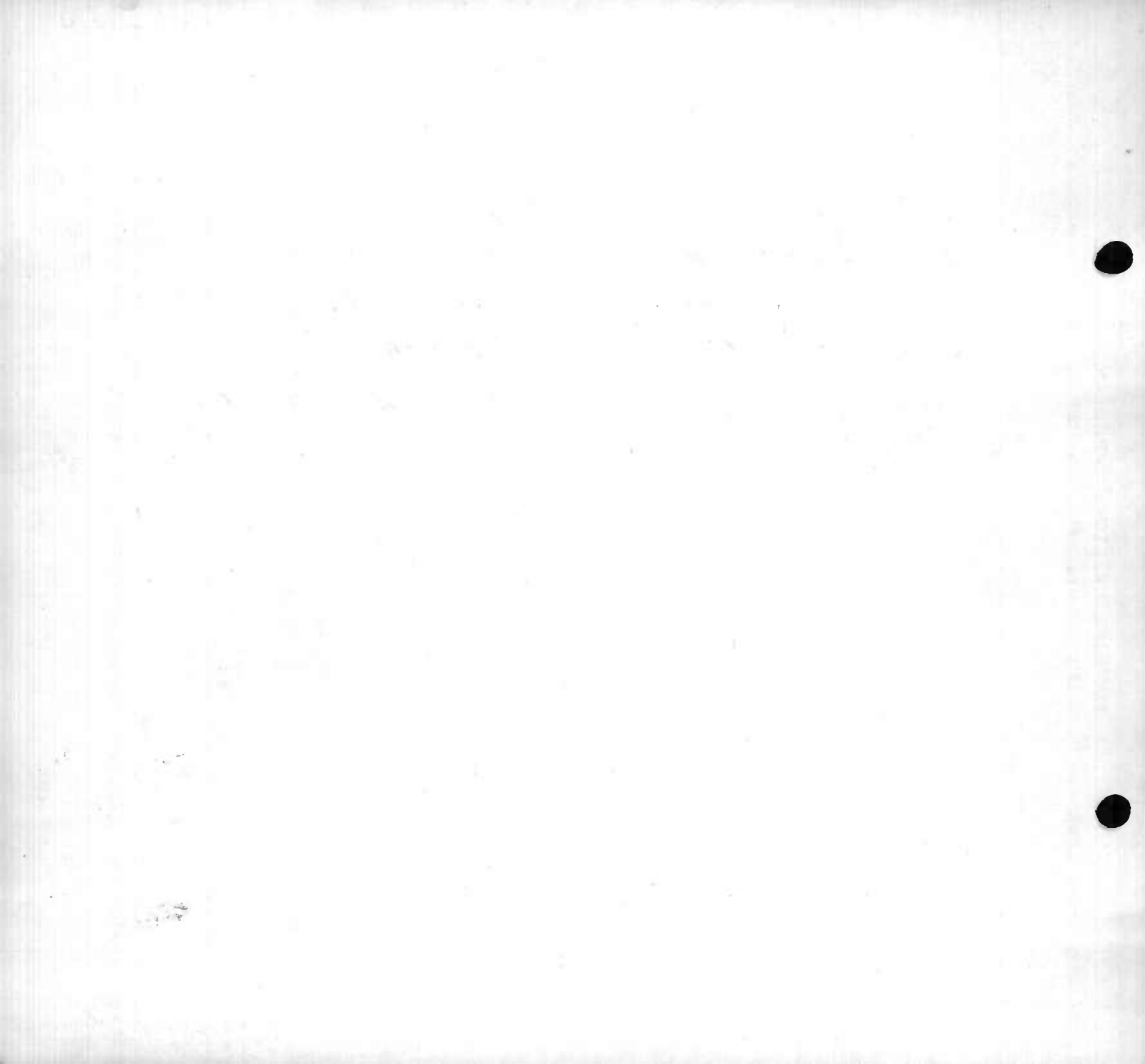
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
44 99 Union Memorial Hospital DOA | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 21218
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3511 Greemount Avenue | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
1909 Jan. 4, 1909 | 9. AGE (In years last birthday)
58 58 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Maintenance | | 10B. KIND OF BUSINESS OR INDUSTRY
Hutzler Dept. Store | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Franklin Carneal | | | | 14. MOTHER'S MAIDEN NAME
Cora Davis | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes War 11 | | 16. SOCIAL SECURITY NO.
215-09-8825 | | 17. INFORMANT
Mary A. Carneal (Wife) Same | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
420.1 Coronary Thrombosis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerosis
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II | | | | INTERVAL BETWEEN ONSET AND DEATH
30 minutes
Three years | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1964 to Oct 29, 1967 , that (I) (we) last saw the deceased alive on August 28, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Franklin E. Leslie | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10-30-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
Franklin E. Leslie M.D. 302 E. 33rd. Street Balto. 21218 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
11/2/1967 | 24C. NAME of CEMETERY or CREMATORY
Dulaney Valley Memorial Gardens | | 24D. LOCATION (City, town, or county) (State)
Cockeysville, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
OCT 31 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jasky, M.D. | | 25C. FUNERAL DIRECTOR
Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 21212 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------|--|------------------|--|-----------------------|--|------------------------|
| H-400 | | 67 10370 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10370 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | | |
| | | | | MAMIE Hill | | | |
| 2. DATE AND HOUR OF DEATH | | | | 10-30-1967 9:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
00 1528 POPLAR GROVE ST | | | | A. STATE MD | | | |
| | | | | B. COUNTY | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | BALTIMORE 16-07 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 1528 POPLAR GROVE ST | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Hours |
| FE | Colored | MARRIED | 4-6-1902 | 65 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Home maker | | at Home | | York Co. S.C. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| John Moore | | | | Sarah | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| no | | | | William Hill | | 1528 Poplar Grove St | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I
420.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.)
MYOCARDIAL INFARCTION UNKNOWN | | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | (B) DUE TO
ARTERIOSCLEROTIC CARDIOVASCULAR DIS. | | | |
| | | | | (C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 24/8/1966 to 10/30/1967, that (I) (we) last saw the deceased alive on 9/6/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| John S. Braxton Jr. | | | | | | 10/31/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| John S. Braxton Jr. | | | | 922 S. SHARP ST., BALT. 30, MD. | | | |
| 24A. BURIAL CREMATION (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 11/2/67 | | Mt Auburn | | Baltimore | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| NOV 1 1967 | | Robert E. Farley, M.D. | | Marshall P. Hays | | 1380 Johnson | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10371 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10371 | |
|--|---------------------|--|-----------------------------------|--|-----------------------|--|------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Guy Mitchell</i> | | | | 2. DATE AND HOUR OF DEATH
<i>October 17, 1967 5:00 P M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF INSTITUTION
<i>38 University Hospital</i> | | (If not in hospital or institution, give street address or location) | | A. STATE
<i>Maryland</i> | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore 4-01</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<i>Morris Hotel Pratt & Estow Place</i> | | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
<i>7-4-00</i> | 9. AGE (In years last birthday)
<i>67</i> | If Under 1 Yr. Months | If Under 24 Hrs. Days | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Roofer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Roofer</i> | | 11. BIRTHPLACE (State or foreign country)
<i>VA</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | |
| 13. FATHER'S NAME
<i>Frederick Mitchell</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Ella Hinkle</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 18. <i>420.1 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <i>B. Middle Cerebral Art Thrombosis</i>
DUE TO
(B) <i>Acute myocardial Infarction</i>
DUE TO
(C) <i>Arteriosclerotic Cardio-vasc. dis</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>7 days</i>
<i>7 days</i>
<i>10-20 yrs</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10-11</i> <i>1967</i> to <i>10-17</i> <i>1967</i> , that (I) (we) last saw the deceased alive on <i>10-17</i> <i>1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Gary M. Latten</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>10/17/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>GARY M. LATTEN</i> | | | | 23D. ADDRESS
M.D. <i>University Hospital Baltimore, Md</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<i>10/30/67</i> | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>NOV 1 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley, MD</i> | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD | | | | | | | |

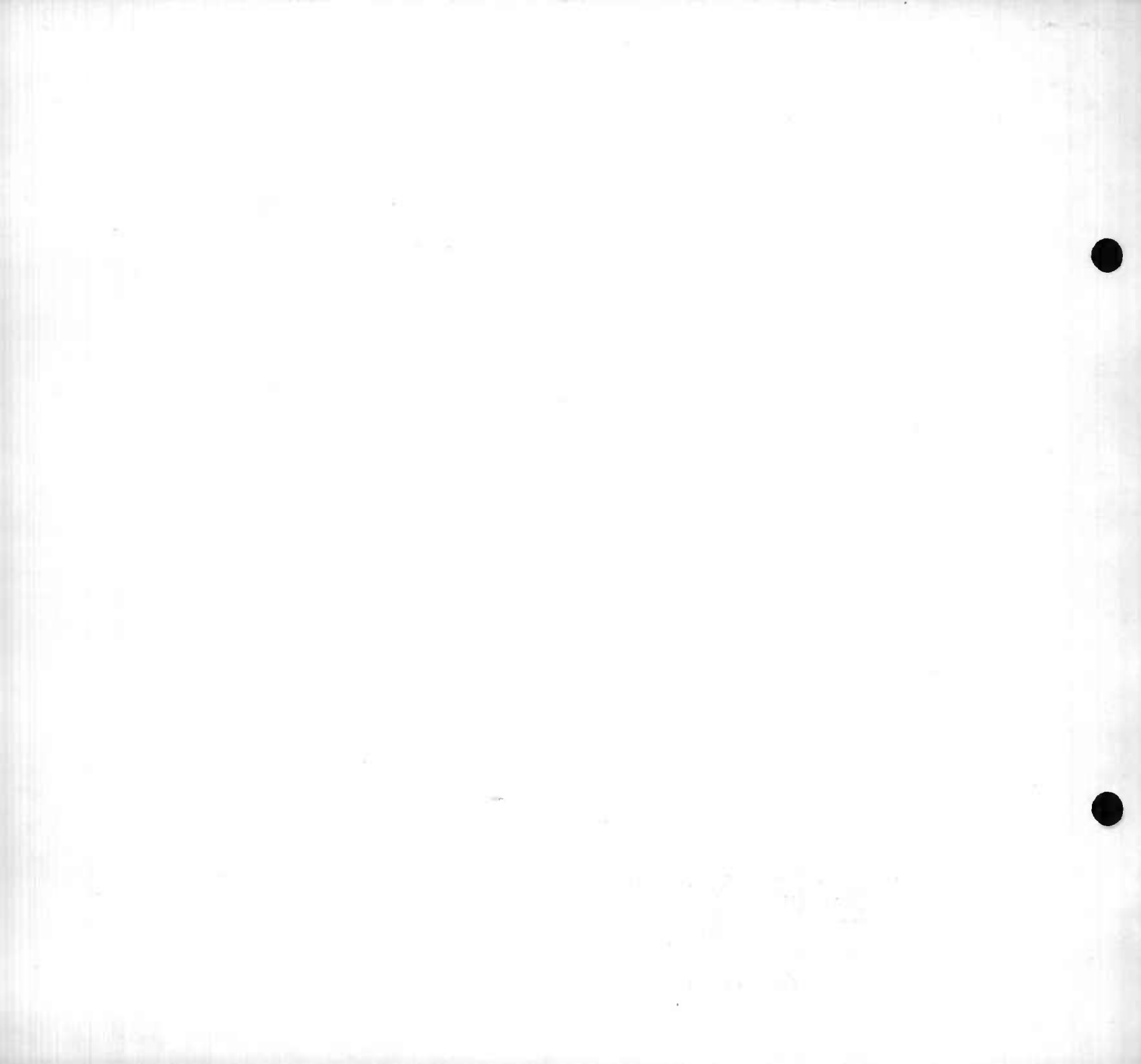
48-32-43

ME

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|------------------------------------|---|--|
| BIRTH NO. 5-20-1896 67 10372 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10372 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Virginia Greenwood | | 2. DATE AND HOUR OF DEATH
10/15/67 12:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 26-44 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 BALTIMORE CITY HOSPITALS
49040 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | D. STREET ADDRESS (If rural, give location)
905 N. KRESSON ST. | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
3-20-96 | 9. AGE (In years last birthday)
71 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
212-32-6840 | | 17. INFORMANT
RECORDS: BCH 4940 EASTERN AVENUE BALTIMORE 21224 | |
| 18. 172X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) METASTATIC CARCINOMA
DUE TO
SITE UNDETERMINED - PRESUMABLY
(B) EMPHYSEMA FROM CHRONIC BRONCHITIS
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
8 months | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-8 19 67 to 10-15 19 67 , that (I) (we) last saw the deceased alive on 10-15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Jack Brandes | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10-15-67 | |
| 23C. PHYSICIAN'S NAME (Type)
JACK BRANDES | | 23D. ADDRESS
M.D. 4940 EASTERN AVENUE BALTIMORE MARYLAND 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
10/30/67 | | 24C. NAME OF CEMETERY or CREMATORY
ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, MD | | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | |



1
A-654

67 10373 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10373

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DAVID ARNOLD

2. DATE AND HOUR PRONOUNCED DEAD

October 8, 1967 1:50 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 16 N. Calhoun St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

16 N. Calhoun St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 9, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

10/27/67

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

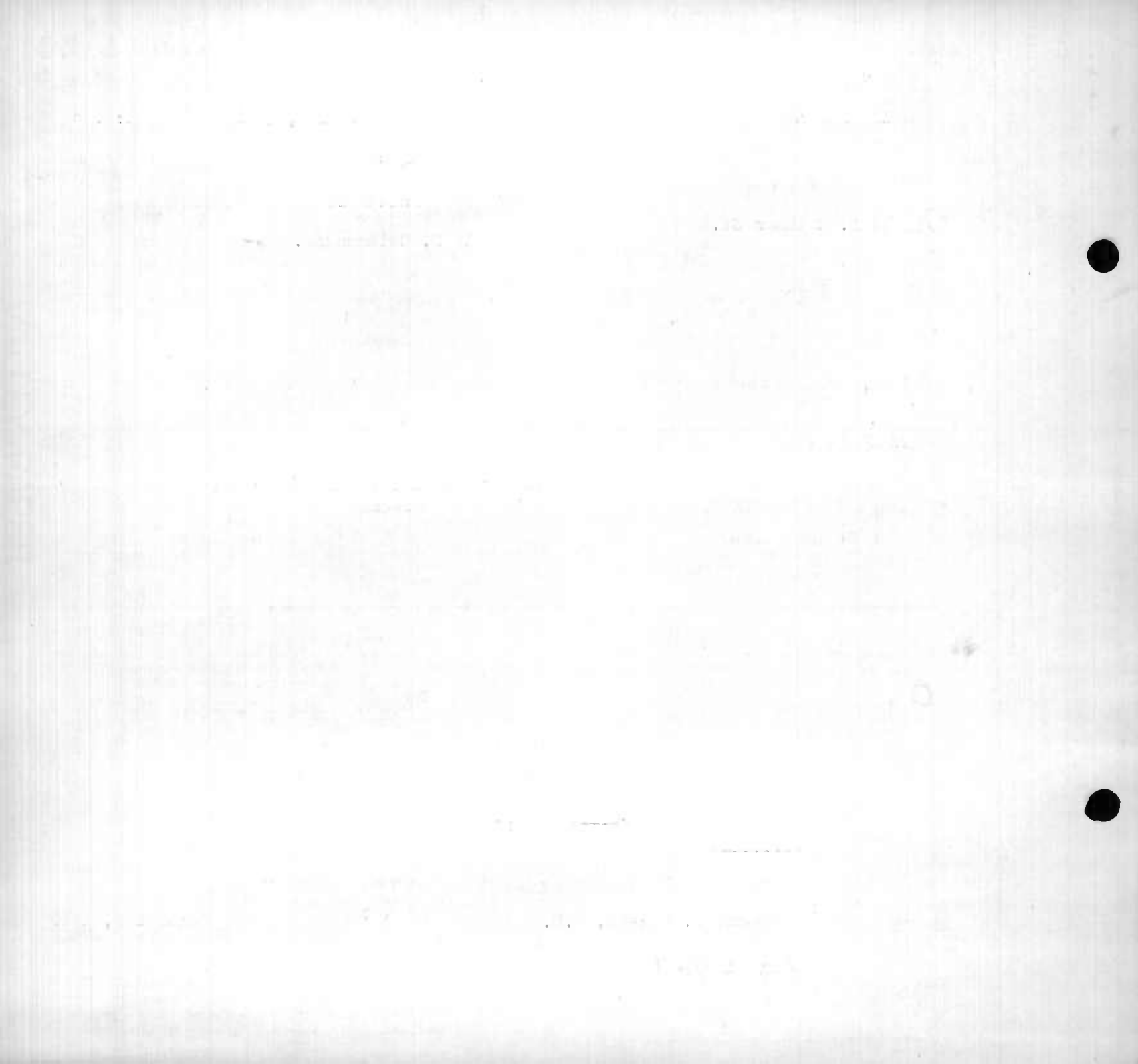
24C. FUNERAL DIRECTOR

ADDRESS

NOV 1 1967

Robert E. Fairley, M.D.

MORTUARY SERVICE - BCHD



CERTIFICATE OF DEATH

Registered No.

67 10374

67 10374

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Posley, Dock

2. DATE AND HOUR OF DEATH

10-5-1967

7.10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS

(If rural, give location)

4940 Eastern Avenue, Baltimore City Hospitals

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1882

9. AGE (In years
lost birthday)

85

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) _____
DUE TO

ASCVD

ANTECEDENT CAUSES

(B) _____
DUE TODISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-2-19 64 to 10-5-19 67,
that (I) (we) last saw the deceased alive on 10/5/67 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

10/5/67

23C. PHYSICIAN'S
NAME (Type)

Jack Brandes

M.D.

4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

10-20-67

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

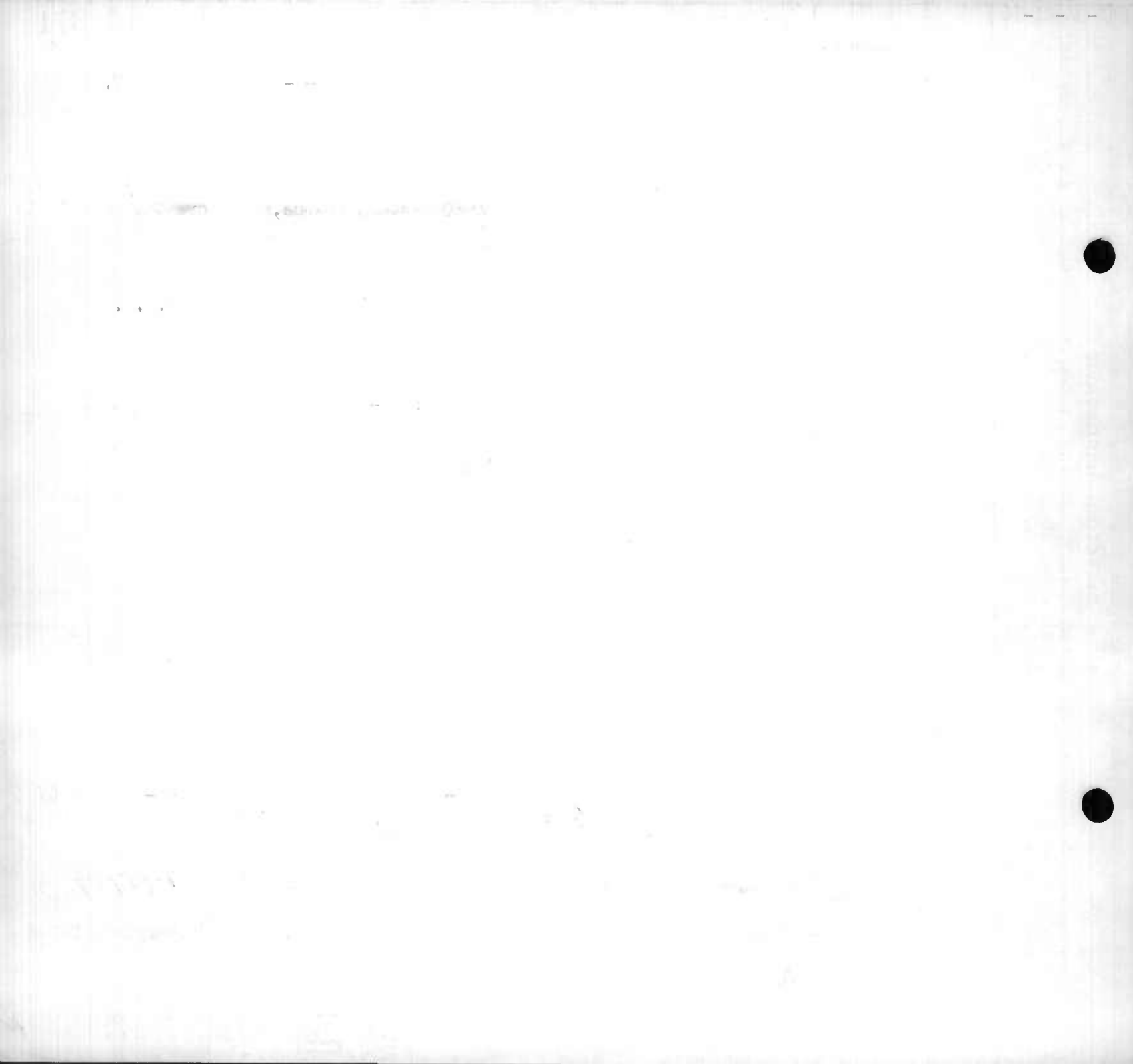
NOV 1 1967

Robert E. Farber, M.D.

MORTUARY SERVICE - BCHD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



67 10375

BALTIMORE CITY HEALTH DEPARTMENT

67 10375

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

AARON COOPER

2. DATE AND HOUR PRONOUNCED DEAD

October 17, 1967 4:00 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1617 Druidhill Ave. DRUID HILL AVE

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

D.O.A.

8. DATE OF BIRTH

9. AGE (in years last birthday)

80

10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Emphysema, left DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive Cardiovascular Disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION, REMOVAL (Specify)

23B. DATE

10/27/67

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

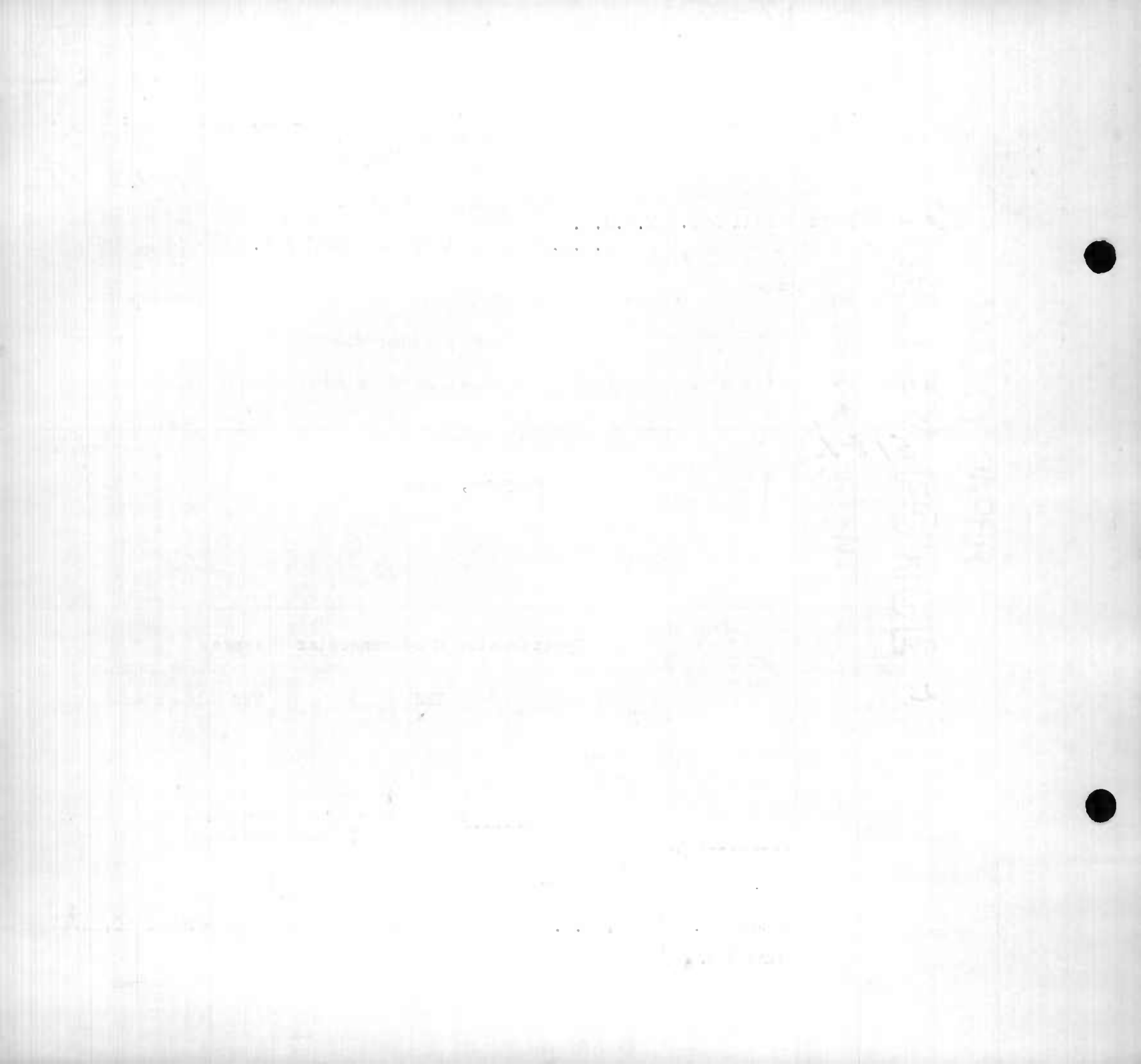
24C. FUNERAL DIRECTOR

ADDRESS

NOV 1 1967

Robert E. Farley, M.D.

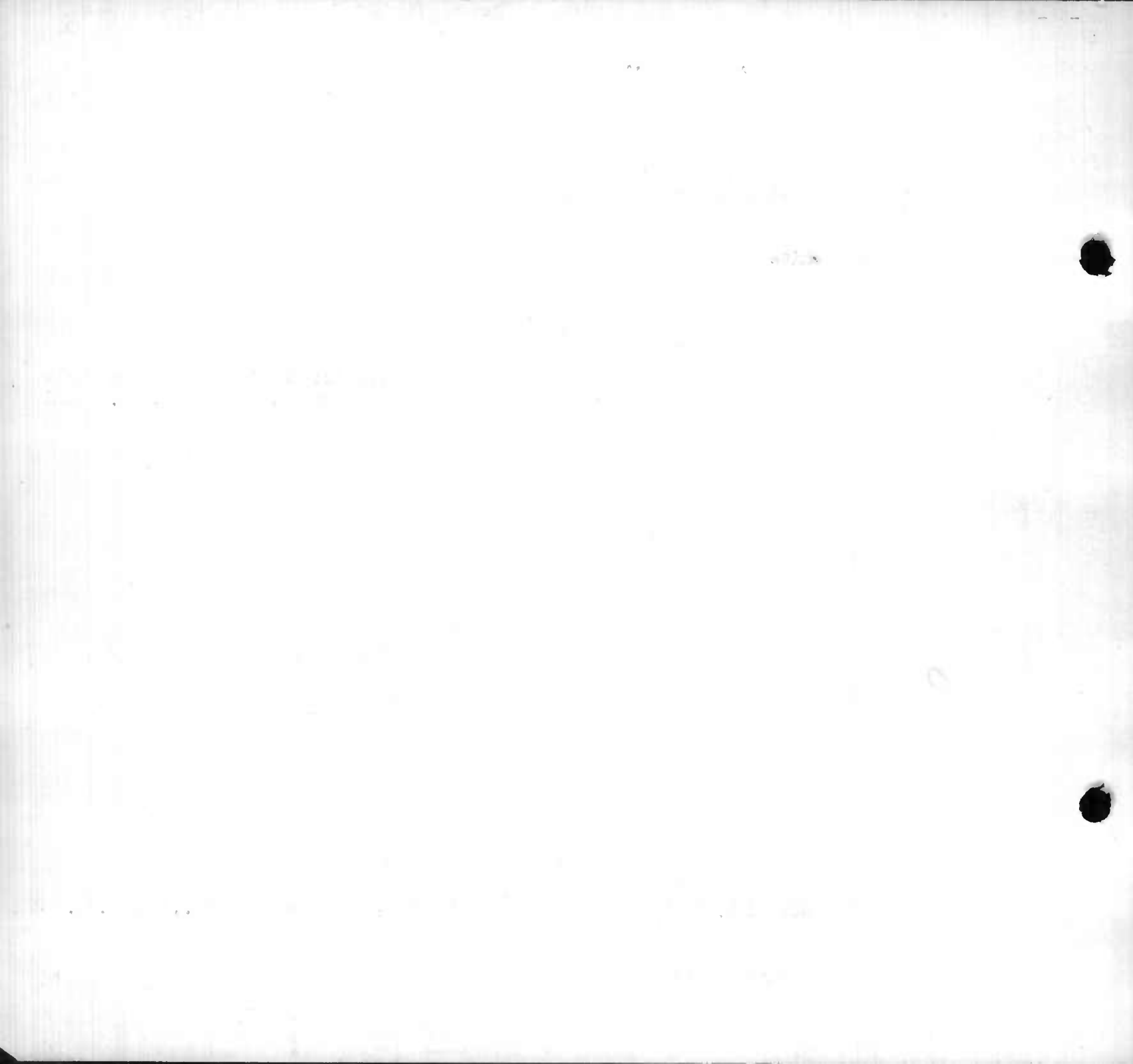
MORTUARY SERVICE



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

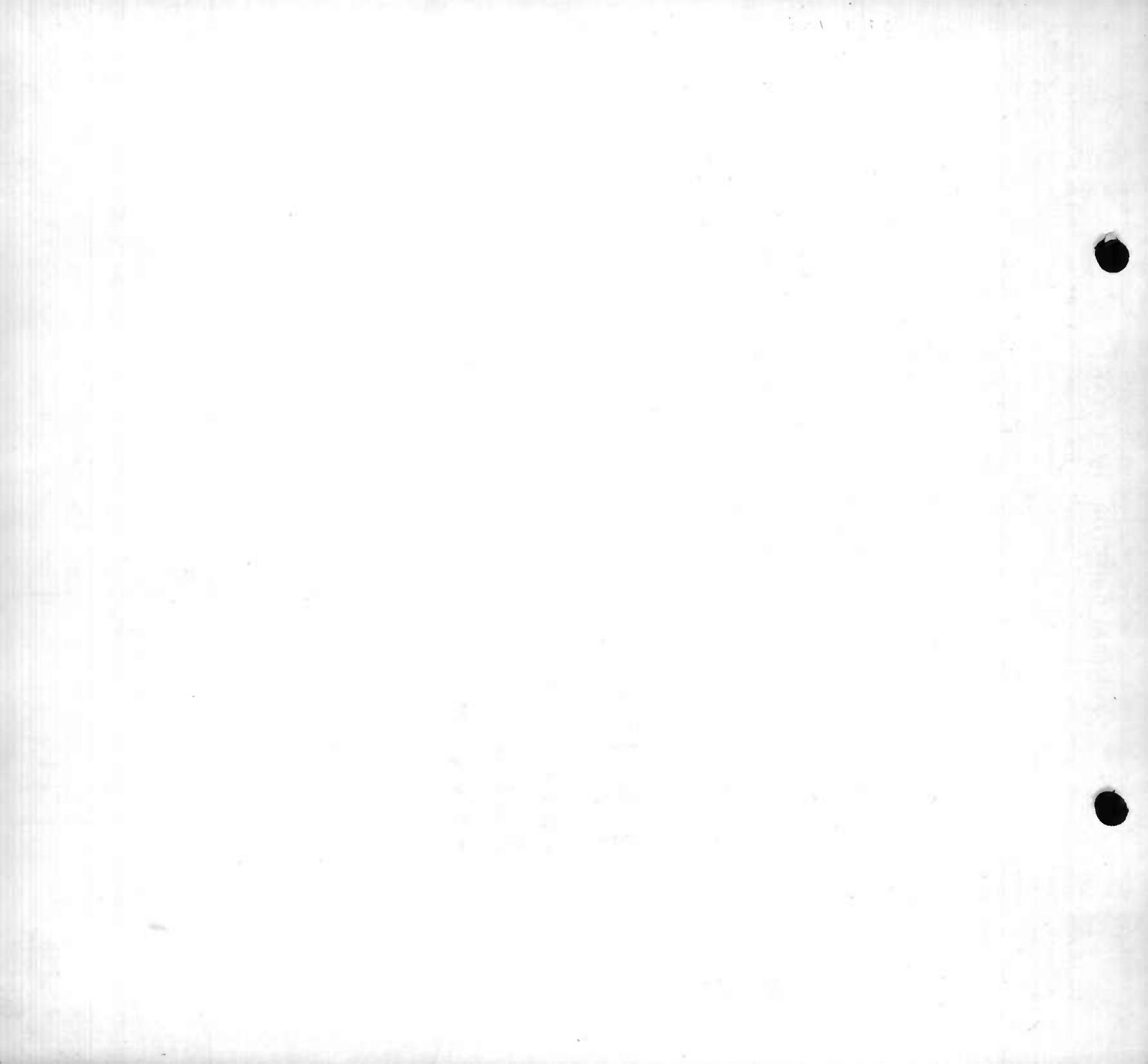
| | | | | | |
|---|-------------------------|--|------------------------------------|--|--|
| BIRTH NO. 67 10376 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10376 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
Cox, Warren G. | | 2. DATE AND HOUR OF DEATH
10/10/67 13:55 9 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY Baltimore | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Baltimore City Hospitals | | (If not in hospital) or institution, give street address and location
4940 Eastern Avenue
Baltimore, Maryland 21224 | | D. STREET ADDRESS (If rural, give location)
11 N. High St. 21202 | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
4/15/82 | 9. AGE (In years lost birthday)
85 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
212-16-6226A | | 17. INFORMANT Records: Baltimore City Hospitals
4940 Eastern Avenue, Baltimore, Md. 21224 | |
| 18. 465X + 153.8
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Prob. Pulmonary Embolism
DUE TO
(B) _____
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
48 hours | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Adenocarcinoma Colon | | | |
| 19A. DATE OF OPERATION
1-1966 BCHA | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cn Colon | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 9/25/67 19 to 10/10/67 19, that (1) (we) last saw the deceased alive on 10/9/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
Robert N. Hill M.D. | | 23B. DATE SIGNED
10/10/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Robert N. Hill | | 23D. ADDRESS
BCH, 4940 Eastern Ave., Balto, Md. 21224 | | 23E. PHYSICIAN'S NAME (Type)
ANATOLY P. PAVLOV M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
10/20/67 | | 24C. NAME OF CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. NAME OF REGISTRAR
Robert E. Fairbank | | 24F. FUNERAL DIRECTOR
UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |
| 24G. DATE RECEIVED BY HEALTH DEPT.
NOV 1 1967 | | 24H. NAME OF REGISTRAR | | 24I. FUNERAL DIRECTOR | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

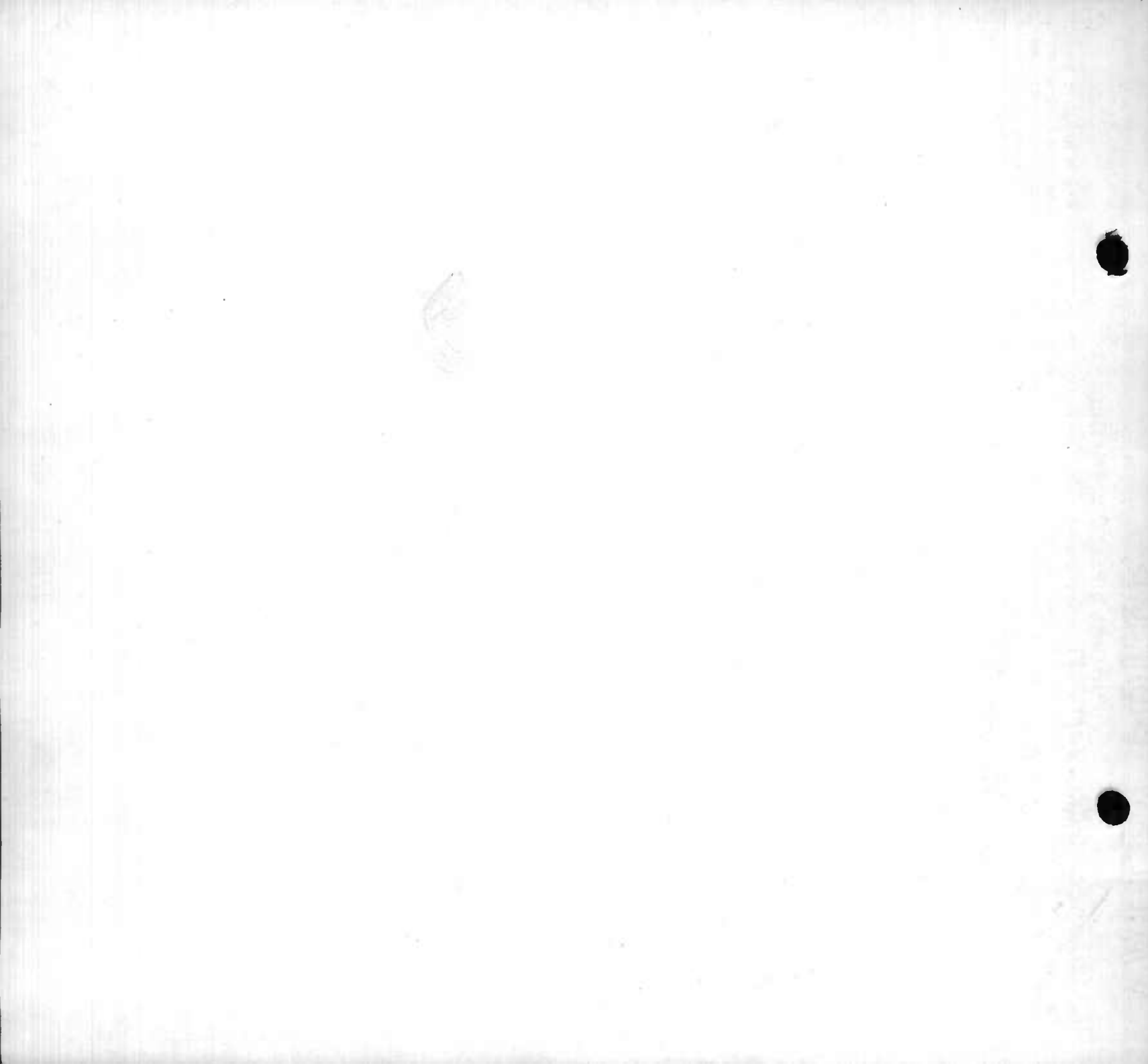
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 10377</u> | |
|--|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. <u>67-20104 67 10377</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Baby Girl Lemon</u> | | 2. DATE AND HOUR OF DEATH
<u>10/20/67 17:15 P. M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>38 Univ. of Md. Hosp.</u> | | A. STATE <u>Md.</u>
B. COUNTY <u>Balto. City</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>1057 W. Fayette St.</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>Negro</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>never married</u> | 8. DATE OF BIRTH
<u>10/7/67</u> | 9. AGE (in years last birthday)
<u>13</u> | If Under 1 Yr. Months: Days: Hours: Min.
<u>13</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>Hugh Witherspoon</u> | | 14. MOTHER'S MAIDEN NAME
<u>Jean Lemon</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Jane McCaffrey, M.D.</u> | |
| 18. <u>774X1</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Prematurity</u> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 weeks</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Patent ductus arteriosus</u> | | | | <u>2 weeks</u> | |
| 19A. DATE OF OPERATION
<u>21</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>10/7</u> 19 <u>67</u> to <u>10/20</u> 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>10/20</u> 19 <u>67</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Jane E. McCaffrey</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>10/20/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>10/30/67</u> | | 24C. NAME of CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT.
<u>NOV 1 1967</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Farley, M.D.</u> | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | 25E. HOSPITAL DISPOSAL | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|---|--|--|
| BIRTH NO. <u>67-25149</u> <u>67 10378</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>67 10378</u> | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Bela Gerl Costley "B"</u> | | | 2. DATE AND HOUR OF DEATH
<u>10/17/67</u> <u>4</u> <u>A.M.</u> | | |
| 3. PLACE OF DEATH <u>IN BALTIMORE, MARYLAND</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD.</u>
B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>38 University Hosp.</u> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>16-08</u> | | |
| | | | D. STREET ADDRESS (If rural, give location)
<u>808 Wildwood Plw.</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>N</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
<u>10/16/57</u> | 9. AGE (In years last birthday)
<u>10</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>Vernon Costley</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Edna</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Immaturity</u> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>(1)</u> <u>this hospital</u> attended the deceased from <u>10/1/67</u> to <u>10/17/67</u> , that <u>(1)</u> <u>(we)</u> last saw the deceased alive on <u>10/17/67</u> and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(1)</u> <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Albert Rosenstein</u> | | | | 23B. DATE SIGNED
<u>10/17/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>ALBERT ROSENSTEIN</u> | | | | 23D. ADDRESS
M.D. | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>10/30/67</u> | | 24C. NAME OF CEMETERY or CREMATORY | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>NOV 1 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Falkner</u> | | 25C. FUNERAL DIRECTOR
<u>HOSPITAL DISPOSAL</u> | |
| | | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---|--|---|---|---|---|---|--|--|
| BIRTH NO. 67 10379 | | | | | CERTIFICATE OF DEATH | | | | |
| Registered No. 67 10379 | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Baby Boy FRANKLIN | | | | | 2. DATE AND HOUR OF DEATH
10-25-67 7:13 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
38 Univ. Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md. Baltimore
B. COUNTY 25-32
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 21225
D. STREET ADDRESS (If rural, give location)
1204 Cherry Hill Rd. | | | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
10-24-67 | 9. AGE (In years lost birthday)
— | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Univ. Hosp. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | |
| 13. FATHER'S NAME
William Franklin | | | | | 14. MOTHER'S MAIDEN NAME
Shirley Franklin | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
patient chart @ U.H. (35-51-04) | | | ADDRESS | |
| 18. 762.5 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH
(A) DUE TO Prematurity
(B) DUE TO Immature lungs - aspiration
(C) | | | INTERVAL BETWEEN ONSET AND DEATH
Since birth - | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-24-1967 to 10-25-1967 , that (I) (we) last saw the deceased alive on 10-25-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Misbah Khan M.D. | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
10-25-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Misbah Khan M.O. | | | | | 23D. ADDRESS
University Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
10-25-67 | | 24C. NAME OF CEMETERY or CREMATORY | | | 24D. LOCATION (City, town, or county) (State)
UNIVERSITY MEDICAL SCHOOL | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | | 25B. NAME OF REGISTRAR
Robert E. Farber, M.D. | | | 25C. FUNERAL DIRECTOR
HOSPITAL DISPOSAL | | | |

July 27th

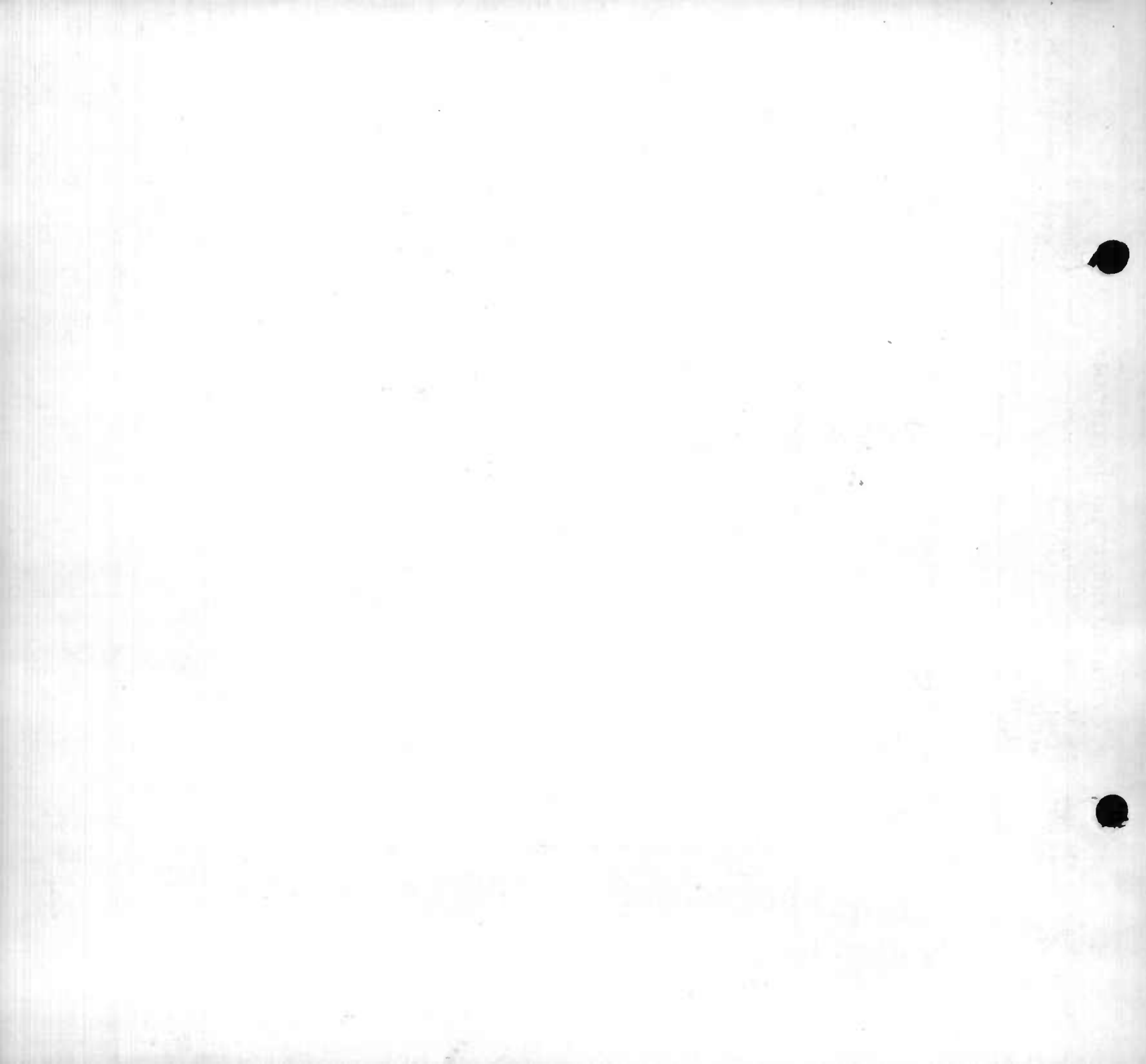
July 28th

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10380 | |
|---|----------------|---|---|--|--|
| BIRTH NO. 67-25148 | | 67 10380 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) B. Grl Castle, "A" | | | 2. DATE AND HOUR OF DEATH
10/17/67 12 30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
38 Univ. Hosp | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)
A. STATE Md.
B. COUNTY Balto.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-08
D. STREET ADDRESS (If rural, give location) 808 Wildwood Parkway | | |
| 5. SEX
F | 6. RACE
W C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
10/16/67 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 1 Hr. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Md. | |
| 13. FATHER'S NAME
Vernon Conley | | | 14. MOTHER'S MAIDEN NAME
Edna | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtemia, etc. It means the disease, injury or complication which caused death.)
776X I
Immatuity | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO
(C) | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 10/13 19 67 to 10/17 19 67, that (I) (we) last saw the deceased alive on 10/17 19 67 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
A. Rosenstein | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/17/67 |
| 23C. PHYSICIAN'S NAME (Type)
ALBERT ROSENSTEIN | | | 23D. ADDRESS
M.D. | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | 24B. DATE
10/30/67 | | 24C. NAME OF CEMETERY or CREMATORY
ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR
UNIVERSITY MEDICAL SCHOOL
HOSPITAL DISPOSAL BLDG | |

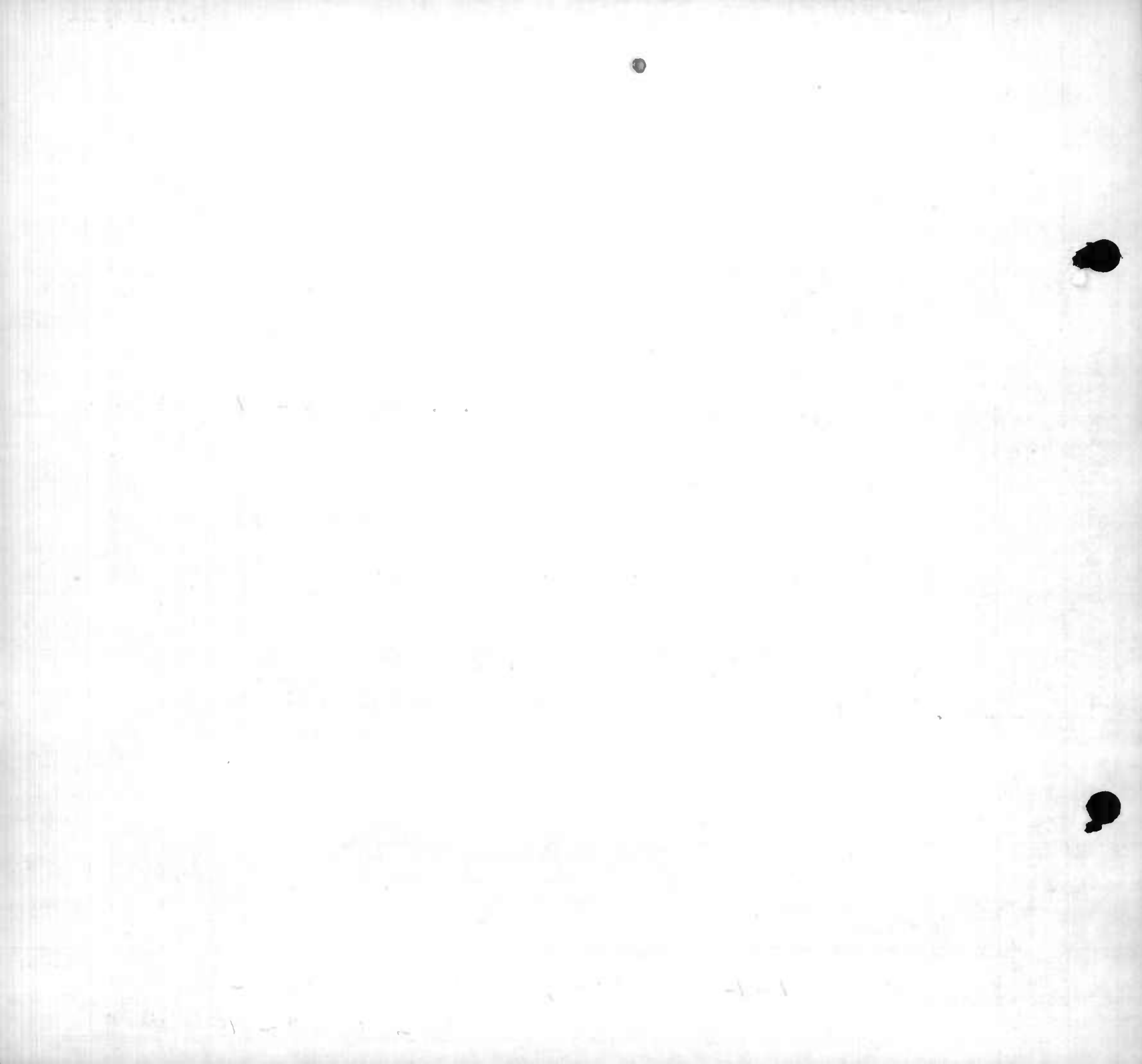


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> 0-260 67 10381 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH Registered No. 67 10381 </div> | | | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) <i>Gussie Owens</i> | | 2. DATE AND HOUR OF DEATH
<i>10/27/67 11:55 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

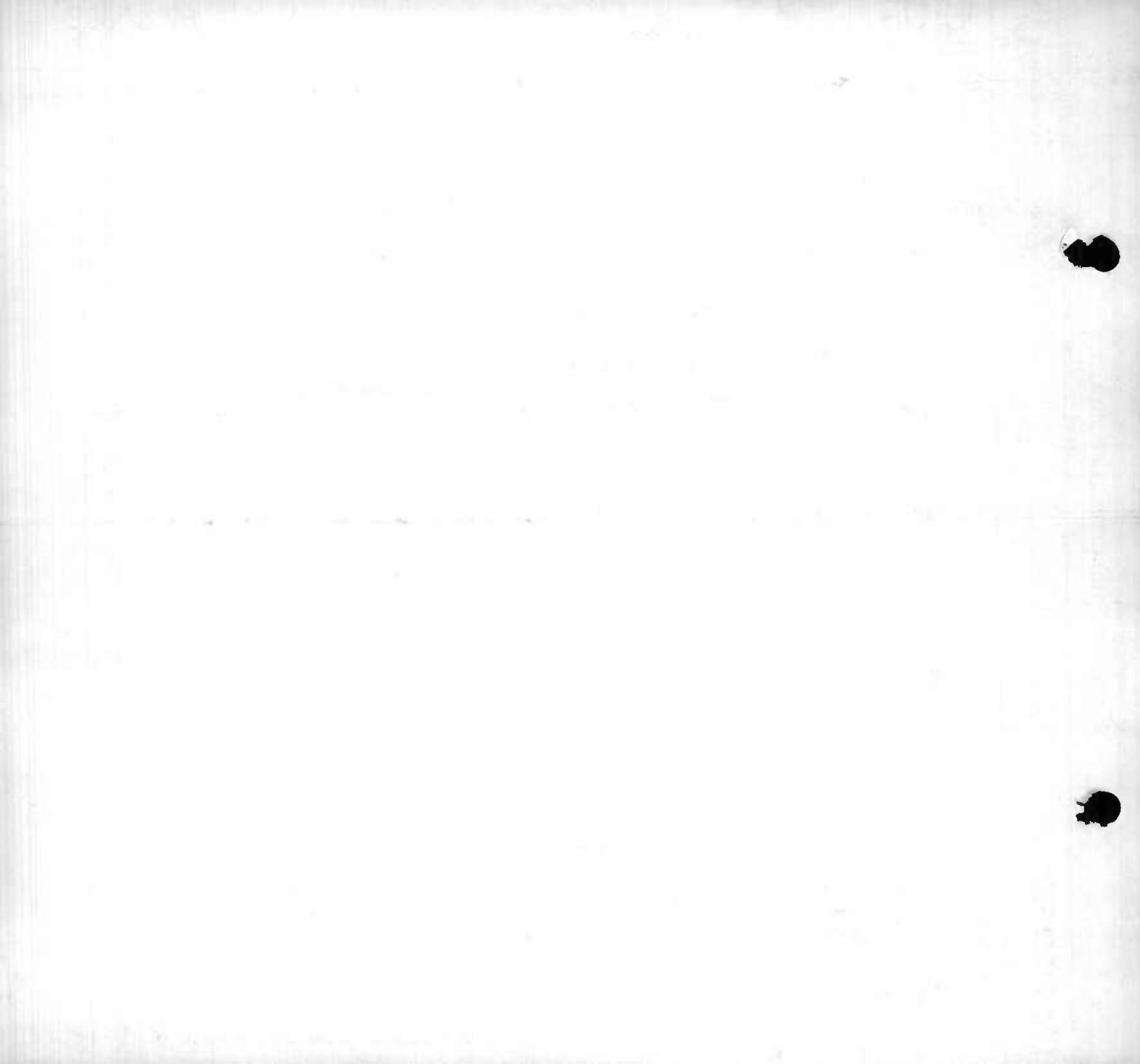
FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
<div style="display: flex; align-items: center;"> 37 <div> <i>MERCY HOSP.</i>
 <i>301 E. PAUL Place</i>
 <i>Baltimore, Md.</i> </div> </div> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>MD.</i>
B. COUNTY _____
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>
D. STREET ADDRESS (If rural, give location) <i>4912 Arabia Ave</i> | |
| 5. SEX <i>F</i> | 6. RACE <i>Caucasian</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>widow</i> | 8. DATE OF BIRTH <i>6/29/1896</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY _____ | 9. AGE (In years last birthday) <i>71</i> |
| 11. BIRTHPLACE (State or foreign country) <i>Sumner County</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>Howard E. White</i> | | 14. MOTHER'S MAIDEN NAME <i>Gussie Shores</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____ | | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT ADDRESS <i>Mr. O. Peter Owens - 4912 Arabia Avenue</i> |
| 18. <i>260 X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>Intractable Congestive Heart Failure was.</i>
DUE TO
(B) <i>Kimmelstiel Wilson Disease yrs.</i>
DUE TO
(C) <i>Diabetes mellitus yrs.</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>Atherosclerosis yrs.</i> | |
| 19A. DATE OF OPERATION <i>2</i> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | 20A. AUTOPSY? (Yes or No) <i>Yes.</i> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____ |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME OF INJURY (APPROX.) _____ | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/5/67</i> 19____ to <i>10/27/67</i> 19____, that (I) (we) last saw the deceased alive on <i>10/27/67</i> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Jean M. Miller</i> M.D. | | 23B. DATE SIGNED <i>10/27/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) _____ | | 23D. ADDRESS _____ M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>10-31-67</i> | 24C. NAME OF CEMETERY or CREMATORY <i>Baltimore, Maryland</i> | 24D. LOCATION (City, town, or county) (State) <i>Baltimore Cemetery</i> |
| 25A. DATE RECD BY HEALTH DEPT. <i>NOV 1 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farkas</i> | 25C. FUNERAL DIRECTOR ADDRESS <i>John L. Miller Inc-6415 Belair Road</i> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|------------------------------------|---|---|
| BIRTH NO. 67 10382 | | Baltimore City Health Department | | Registered No. 67 10382 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) JEFFERSON GRACE | | 2. DATE AND HOUR OF DEATH
10/27/67 12:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Worcester Co. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
SNOW HILL 73-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
38 UNIVERSITY HOSPITAL | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location)
RT. 2 | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
W | 8. DATE OF BIRTH
3/27/13 | 9. AGE (In years last birthday)
54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FINANCE OFFICE WORK | | 10B. KIND OF BUSINESS OR INDUSTRY
Welfare Dept. (ca.) | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
JAMES JEFFERSON Bradford | | 14. MOTHER'S MAIDEN NAME
ALICE HALSTON | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215010139 | | 17. INFORMANT
Mrs. Nina Roe Jones DAUGHTER | |
| 18. 330X1 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) SUBARACHNOID HEMORRHAGE
DUE TO | | 3 WEEKS | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) ANEURYSM IN INTERNAL CAROTID ART.
DUE TO | | | |
| (C) | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
? | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 10/18/67 19 to 10/27/67 19, that (1) (we) last saw the deceased alive on 10/27/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Fred N. Sugar | | | | 23B. DATE SIGNED
10/27/67 | |
| 23C. PHYSICIAN'S NAME (Type)
FRED N. SUGAR | | | | 23D. ADDRESS
M.D. UNIVERSITY HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/29/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Bowen Meth Cemetery | |
| 24D. LOCATION
Newark, Maryland | | (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
James E. Williams, Snow Hill, Md. | |
| ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. | |
|--|------------------|--|--|--|---|
| 67 10383 | | 67 10383 | | 67 10383 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| MARKOWSKI, WLADYSLAW (Walter) | | | 10-28-67 7:15 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNION MEMORIAL HOSPITAL | | | A. STATE
MARYLAND
B. COUNTY
Baltimore | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
53-00 | | |
| D. STREET ADDRESS (If rural, give location)
912 RADCLIFFE ROAD | | | | | |
| 5. SEX
M | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
07-13-93 | 9. AGE (In years lost birthday)
74 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CLERK | | 10B. KIND OF BUSINESS OR INDUSTRY
NONE | 11. BIRTHPLACE (State or foreign country)
POLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
UNKNOWN | | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No None | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
Family records | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. If means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) DUE TO Myocardial infarction 9 months
(B) DUE TO coronary atherosclerosis
(C) M. Halpern 10-28-67 | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-27 1967 to 10-28 1967, that (I) (we) last saw the deceased alive on 10-28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Paul V. Disquitado | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10-28-67 |
| 23C. PHYSICIAN'S NAME (Print)
PAUL V. DISQUITADO | | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL
UNION MEMORIAL HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Oct. 31, 1967 | | 24C. NAME OF CEMETERY or CREMATORY
Dulaney Valley Memorial | |
| 24D. LOCATION
Cockeysville, Maryland | | 24E. CITY, TOWN, or county | | 24F. STATE
(State) | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
John Burns' Sons, Towson, Maryland | |
| 25D. ADDRESS | | | | | |

7577

BLACKBURN HOSPITAL

15 APR 45

ACTIVE

915 RADCLIFFE ROAD

UNION MEMORIAL HOSPITAL

07-13-41 74

M WHITE WILSON

11

POLAND

WONE

CLEER

UNKNOWN

UNKNOWN

M. J. ...

...

[Handwritten signature]

10-15

10-15

10-15

10-15

...

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-----------------------------|---|--|
| BIRTH NO. 67 10384 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10384 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Charles B. Mullen | | 2. DATE AND HOUR OF DEATH
10/30/67 7 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
33 THE JOHNS HOPKINS HOSPITAL
BALTIMORE, MD 21205 | | A. STATE
MARYLAND | | | |
| | | B. COUNTY
Harford Co | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
11 BELAIR BEL AIR 62-00 | | | |
| | | D. STREET ADDRESS (If rural, give location)
P.O. BOX 701 | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
12-4-95 | 9. AGE (In years lost birthday)
71 | 10. Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Projectionist | | 10B. KIND OF BUSINESS OR INDUSTRY
Movie Theatre | | 11. BIRTHPLACE (State or foreign country)
Mississippi | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
JOHN MULLEN | | | |
| 14. MOTHER'S MAIDEN NAME
CORA MCCALIP | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
428-05-5992 | | 17. INFORMANT
Box 71
Edna M. Wilson, Bel Air, Maryland | | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Probable Myocardial Disease
DUE TO
arrhythmia? Infarct?
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
23 AM - 7 AM
3 hours | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 24 1967 to Oct 30 1967, that (I) (we) last saw the deceased alive on Oct 30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Ron E. Smith | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/30/67 | |
| 23C. PHYSICIAN'S NAME (Type)
RON E. SMITH | | 23D. ADDRESS
M.D. THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/2/67 | | 24C. NAME OF CEMETERY or CREMATORY
Oak Grove Bapt. Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Bel Air (Harford) Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farkner | | 25C. FUNERAL DIRECTOR
Tarring Funeral Home
11111 Aberdeen, Md. | | | |

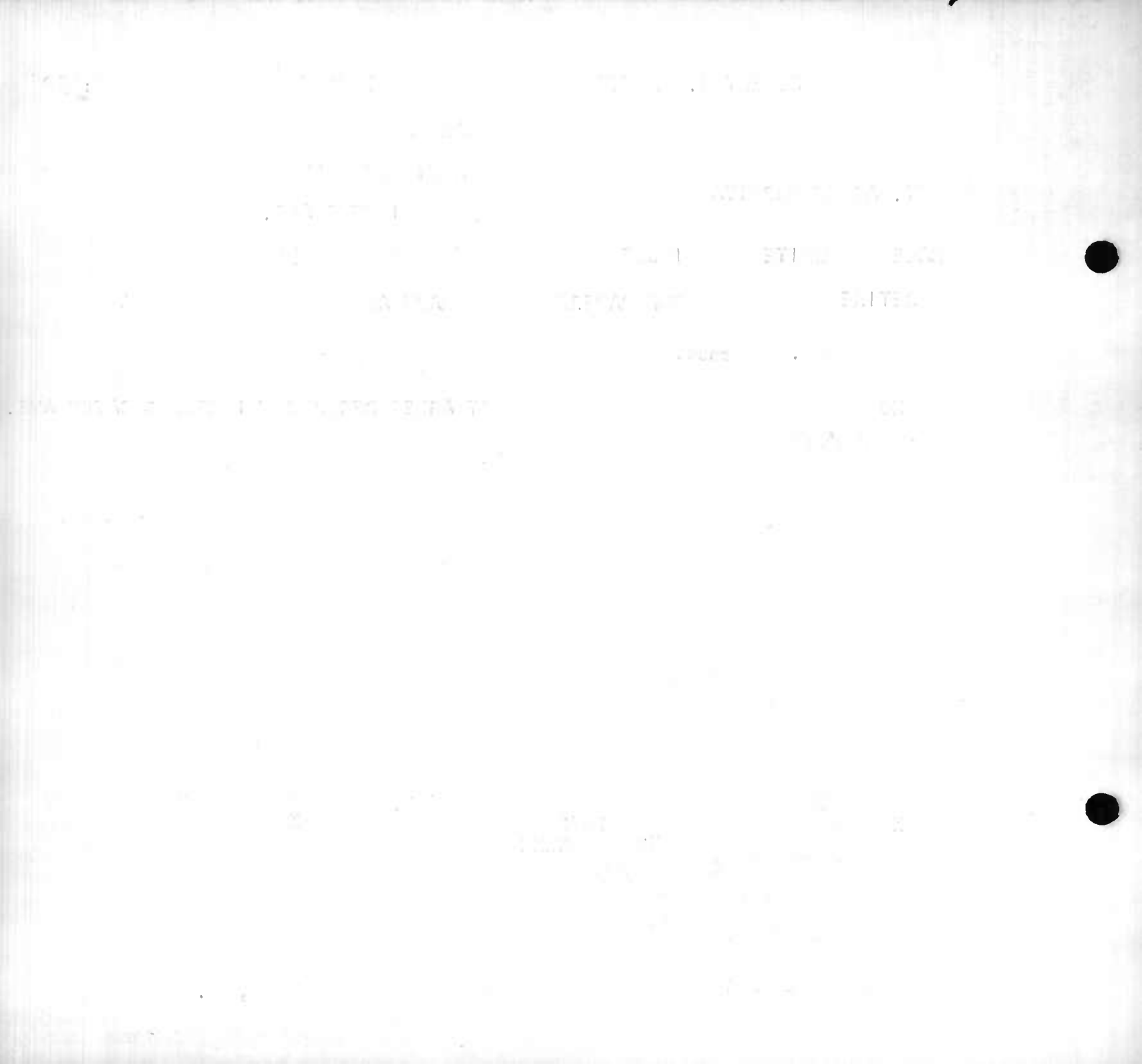
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10386 | |
|---|--------------------------------|--|---|---|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 10386 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) ROBERT E. PRUETT | | | 2. DATE AND HOUR OF DEATH
10/29/67 6:25 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY _____
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 21229
D. STREET ADDRESS (If rural, give location)
3418 WILKENS AVE. | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED | 8. DATE OF BIRTH
01/11/95 | 9. AGE (In years last birthday)
72 | If Under 1 Yr. Months: _____ Days: _____ Hours: _____ Min. _____
If Under 24 Hrs. _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY
SUN PAPERS | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
Robert A. Pruett | | | 14. MOTHER'S MAIDEN NAME
Myers | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
ST AGNES RECORDS WILKENS & CATON AVE. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

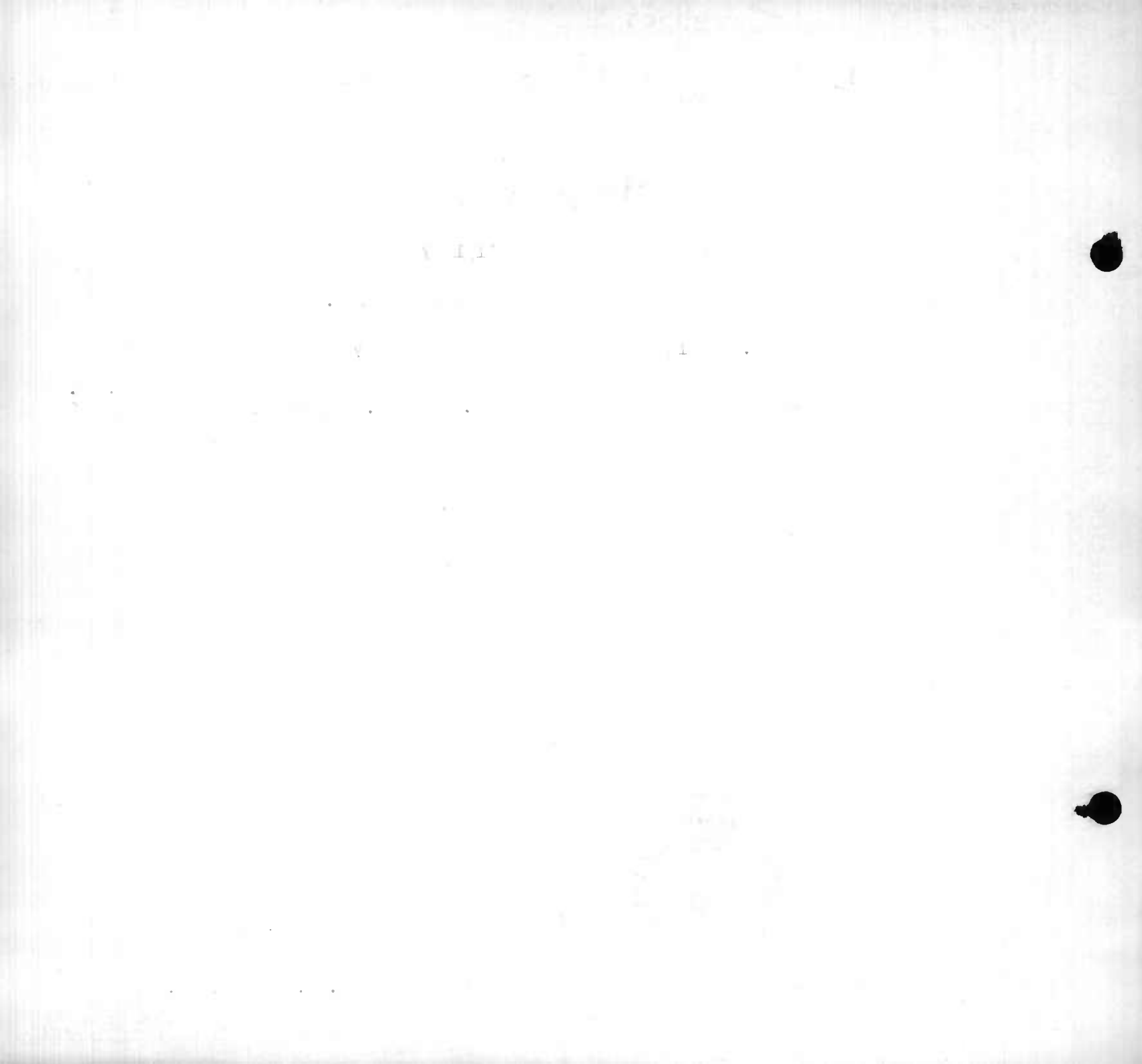
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) DUE TO <i>Pneumonia</i>
(B) DUE TO <i>Proteinuria</i>
(C) <i>Bronchopneumonia</i> | | INTERVAL BETWEEN ONSET AND DEATH |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/29 19 67 to 10/29 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/29 19 67 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>GEORGE ANCOV</i> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
GEORGE ANCOV | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/1/67 | | 24C. NAME OF CEMETERY or CREMATORY
Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR
<i>Wm. J. Tichner</i> | |
| ADDRESS <i>Balto, Md.</i> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 67 10385 | |
|--|---------------------|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 10385 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Damm Bertha | | | 2. DATE AND HOUR OF DEATH
10-24-67 12.10 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
46 Lutheran Hospital | | | A. STATE MD. | | |
| (If not in hospital or institution, give street address or location) | | | B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location)
2419 WEST LANVALE | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
W. | 8. DATE OF BIRTH
2/1887 | 9. AGE (In years last birthday)
80 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, M.d | |
| 13. FATHER'S NAME
Herman J. Reinle | | | 14. MOTHER'S MAIDEN NAME
? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No None | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mercantile Sf. Dp. Mr. Louis W. Hargrave 13 South Street #2 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
260X I | | | CAUSE OF DEATH
(A) CVA.
DUE TO
(B) ASVD.
DUE TO
(C) Diabetes | | INTERVAL BETWEEN ONSET AND DEATH
? 3 days |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-22-1967 to 10-24-1967 , that (I) (we) last saw the deceased alive on 10-24-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
N. Turkman | | | | 23B. DATE SIGNED | |
| M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
N. Turkman | | 23D. ADDRESS
Lutheran Hospital | | | |
| M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/28/67 | | 24C. NAME of CEMETERY or CREMATORY
Cedar Hill Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
A. A. County, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Wm. F. Turkman Sons | |
| | | | | ADDRESS
Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10387 | |
|--|-------------------------|--|--|---|---|
| BIRTH NO. 67 10387 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) WILBUR W. ROBERTS | | 2. DATE AND HOUR OF DEATH
10-29-67 10⁰⁰ P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
33 JOHNS HOPKINS HOSPITAL. | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 18
D. STREET ADDRESS (If rural, give location) 2016 E. 31ST. ST | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
1-7-1908 | 9. AGE (In years last birthday)
59 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY
Plumbing Supply | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 13. FATHER'S NAME
CHARLES E. ROBERTS | | | 14. MOTHER'S MAIDEN NAME
MARY INSLEY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes World War II | | 16. SOCIAL SECURITY NO.
213-10-9052 | | 17. INFORMANT
Mrs. Dorothy W. Roberts same address | |
| 18. 163 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
— | | CAUSE OF DEATH
(A) Pneumonia RUL
DUE TO
(B) Emphysema & obstruction RUL
DUE TO
(C) Adenocarcinoma - Lung | | INTERVAL BETWEEN ONSET AND DEATH
3-4 Days

1 year | |
| 19A. DATE OF OPERATION
10-23-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
RUL lung resection | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-13-67 to 10-29 19 67 , that (I) (we) last saw the deceased alive on 10-29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Antonio Gonzalez Revilla Jr. M.D. | | | | 23B. DATE SIGNED
10-29-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Antonio Gonzalez Revilla Jr. | | 23D. ADDRESS
John Hopkins Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/2/67 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farkner | | 25C. FUNERAL DIRECTOR
Wm. F. Tietz & Sons | |
| 25D. ADDRESS
Baltimore, Md. | | | | | |

10-2-01

10-2-01

10-2-01

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10-2-01

10-2-01

10-2-01

10-2-01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------|--|-------------------------|---|--|--|--|
| H-200 | | 67 10388 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10388 | |
| BIRTH NO. | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| FANNIE HESS | | | | OCTOBER 30, 1967 6 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| MT. SINAI NURSING HOME
4613 PARK HEIGHTS AVENUE | | | | MARYLAND
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
6935 FIELDCREST ROAD | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. Under 1 Yr.
Months Days | 11. Under 24 Hrs.
Hours Min. | |
| FEMALE | WHITE | SINGLE | 12-23-1901 | 65 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| RETIRED | | SEAMSTRESS | | BALTIMORE, MARYLAND | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| JOSEPH HESS | | | | HANNAH POTTS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| NO | | | | | MRS. DORA TAYLOR, 3613 SPAULDING AVENUE #21215 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| I
170X | | | | Carcinoma of breast | | 6 months | |
| ANTECEDENT CAUSES | | | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| II | | | | (C) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | here | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | no | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 25 1967 to Oct 30 1967, that (I) (we) last saw the deceased alive on Oct 30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Manuel Levin | | | | 10/30/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| DR. MANUEL LEVIN | | | | 6101 PARK HEIGHTS AVENUE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 10-31-67 | | BETH TFILOH | | BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| NOV 1 1967 | | Robert E. Fisher | | SOL LEVINSON & BROS. INC. | | 6010 REISTERSTOWN RD. | |

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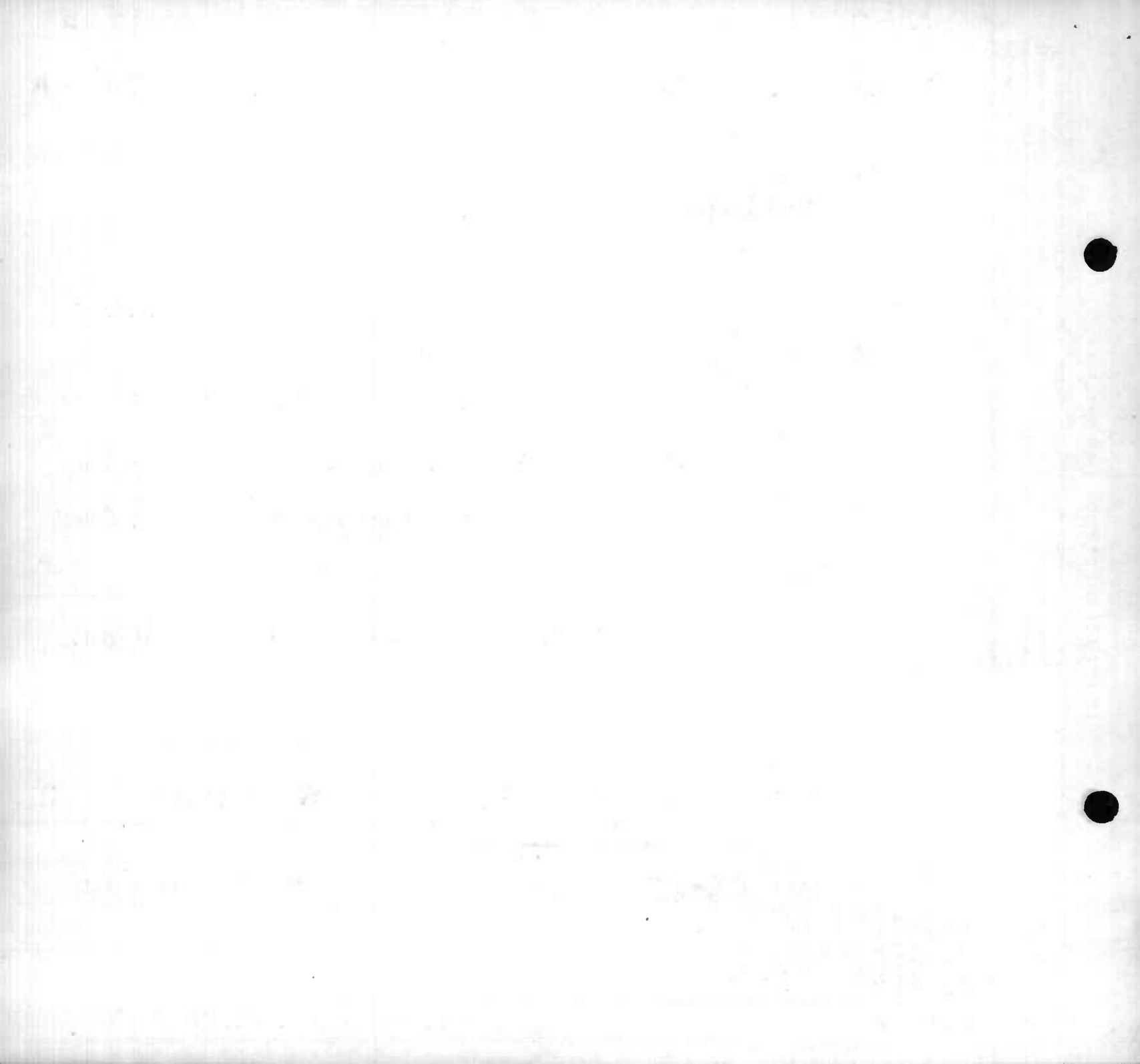
10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10389 | | | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10389 | |
|---|-------------------------|--|---|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) Fannie Kahanovitz KAHANOVITZ | | | | 2. DATE AND HOUR OF DEATH
10/30/67 7:15 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Levindale Hebrew Home and Infirmary | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
4919 EDMERE AVENUE | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
MAY 15, 1889 | | 9. AGE (In years last birthday)
78 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
RUSSIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
MICHAEL BOROSHAFSKY | | | | 14. MOTHER'S MAIDEN NAME
ELSIE ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MRS. JEANETTE RIVLIN, 2703 LIGHTFOOT DRIVE #9 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Prob septecemia
urinary tract infection | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days
? days | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
ASOVD and diabetes mellitus | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 3/21 19 56 to 10/30 19 67 , that (we) last saw the deceased alive on 10/30 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (didn't) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Susan Legat | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/30/67 | |
| 23C. PHYSICIAN'S NAME (Type)
SUSAN LEGAT | | | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-31-67 | | 24C. NAME of CEMETERY or CREMATORY
WORKMEN CIRCLE | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Reuben E. Is... | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10380 | |
|---|--------------------------------|--|---|---|---|
| <div style="display: flex; justify-content: space-between;"> G-652 67 10380 CERTIFICATE OF DEATH </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> BIRTH NO.
 M.E. CASE NO.
 1. NAME OF DECEASED
 (Type or Print) JEROME GARONZIK </div> <div> 2. DATE AND HOUR OF DEATH
 OCT. 22 1967 2:54 P.M. </div> </div> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

<div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION
 42 SINAI HOSPITAL OF BALTIMORE </div> <div> (If not in hospital or institution, give street address or location) </div> </div> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 6003 HIGHGATE DRIVE | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
9-1-1914 | 9. AGE (In years last birthday)
53 | If Under 1 Yr. Months: Days
If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SELF EMPLOYED | | 10B. KIND OF BUSINESS OR INDUSTRY
ELECTRONICS | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
SAMUEL GARONZIK | | |
| 14. MOTHER'S MAIDEN NAME
LENA LEIBOWITZ | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | |
| 16. SOCIAL SECURITY NO.
216-18-6407 | | 17. INFORMANT ADDRESS
MRS. NETTIE GARONZIK, 6003 HIGHGATE DR. #15 | | | |
| 18. CAUSE OF DEATH
<div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 420.1 I
 (This does not mean the mode of dying, e.g., heart failure, apoplexy, etc. It means the disease, injury or complication which caused death.)

 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) DUE TO MYOCARDIAL INFARCTION 4 days

 (B) DUE TO A.S.H.D. 7 yrs

 (C) </div> <div> INTERVAL BETWEEN ONSET AND DEATH </div> </div> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. THORACIC DEFORMITY 2° to POLIO | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10/23</u> 19 <u>67</u> to <u>10/27</u> 19 <u>67</u>, that (I) (we) last saw the deceased alive on <u>10/27</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Richard Katon M.D. | | | | 23B. DATE SIGNED
10/27 | |
| 23C. PHYSICIAN'S NAME (Type)
RICHARD KATON M.D. | | | | 23D. ADDRESS
SINAI HOSPITAL OF BALTIMORE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-29-67 | | 24C. NAME OF CEMETERY OR CREMATORY
JEHUDA AMACHBY | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fairley | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS. INC, 6010 REISTERSTOWN RD. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | 67 10391 | | 67 10391 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | |
| 67 10391 | | 67 10391 | | CLARA M. WEINER | |
| 2. DATE AND HOUR OF DEATH | | 3:30 Oct 28, 1967 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | Maryland | | | |
| SINAI HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | 27-20
3903 Bartwood Road | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| Female | | White | | Divorced | |
| 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| May 1879 | | 88 | | Housewife | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| Austria | | USA | | Michael Morgansstern | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Annie Rice | | No | | 17. INFORMANT ADDRESS
Mrs. Sadie Goldstein 3711 Clarks Lane #15 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.11-260X | | ASCVD | | - years | |
| ANTECEDENT CAUSES | | (A) DUE TO | | Cerebral arteriosclerosis 20 years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | Myocardial infarction - sudden - 3:30 PM | |
| II | | (C) DUE TO | | Diabetes mellitus | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20. DATE OF OPERATION | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3:30 Oct 28 19 17 to 3:30 PM 19 17, that (I) (we) last saw the deceased alive on 3:30 PM 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. - DOA | | 23A. SIGNATURE | | 23B. DATE SIGNED | |
| A S GLUSHAKOV | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | Oct 28/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 24A. BURIAL CREMATION, REMOVAL (Specify) | |
| A S GLUSHAKOV | | SINAI HOSPITAL | | Burial | |
| 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 10/19/1967 | | Shaarei Zion | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| NOV 1 1967 | | R. E. Taylor, M.D. | | Sol Levinson & Bros. 6010 Reisterstown Road | |

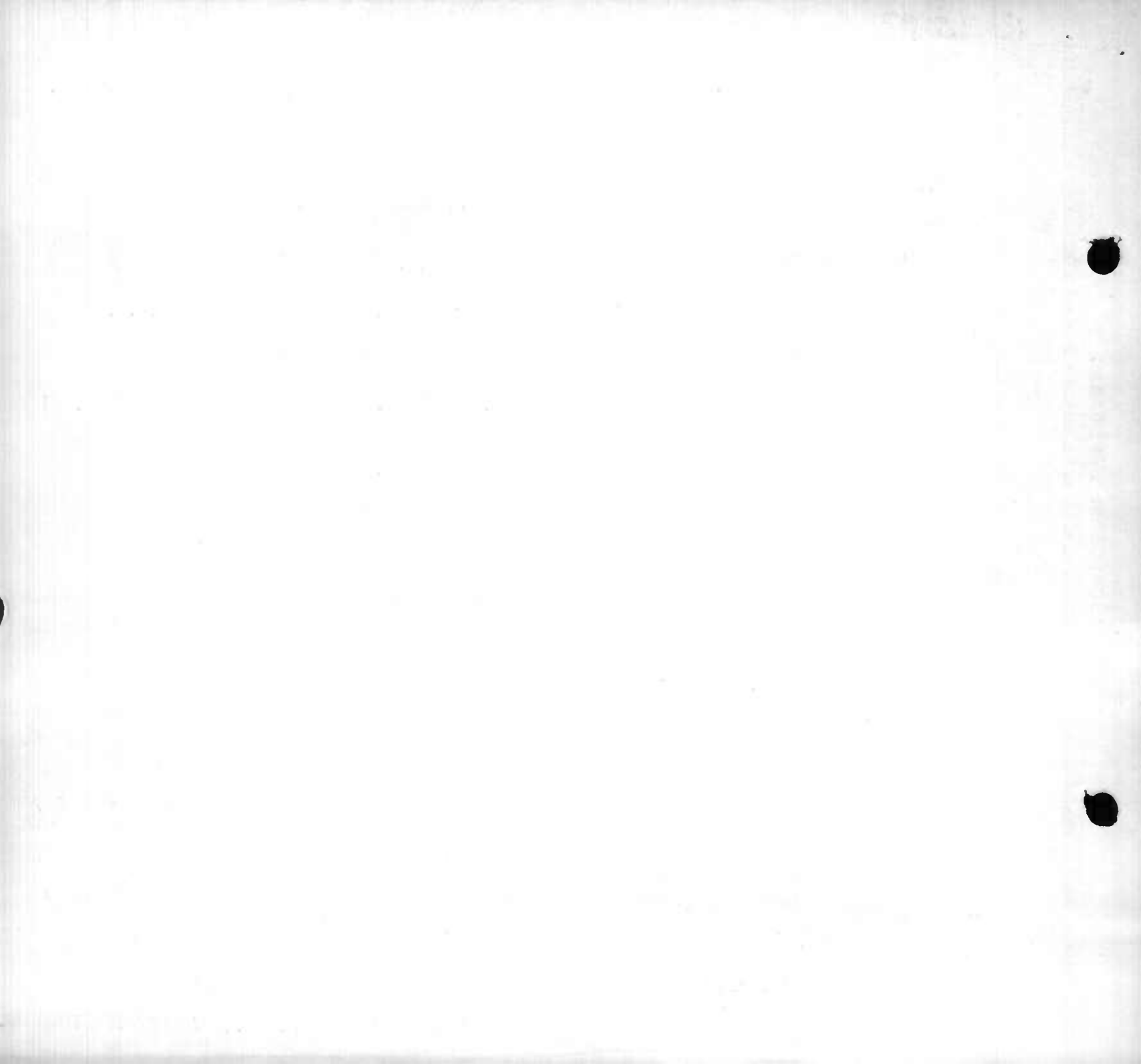
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10392 |
|--|---|--|---|--|
| BIRTH NO. 67 10392 | | CERTIFICATE OF DEATH | | |
| M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| SYLVIA D. RICHMOND | | OCTOBER 30, 1967 5:30 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

6214 BENHURST ROAD
00 | | A. STATE
MARYLAND | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | |
| | | D. STREET ADDRESS (If rural, give location)
6214 BENHURST ROAD | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
APRIL 9, 1916 | 9. AGE (In years last birthday)
51 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | |
| 13. FATHER'S NAME
LATE HARRY GOLDINER | | 14. MOTHER'S MAIDEN NAME
LIVING GERTRUDE KLIGMAN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
MR. SEWELL E. RICHMOND, 6214 BENHURST RD. #9 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of Bowel | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |
| 19A. DATE OF OPERATION
10-31-67 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-30-67 to 10-30-67 , that (I) (we) last saw the deceased alive on 10-30-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<i>Jerome Coller</i> | | 23B. DATE SIGNED
10-30-67 | | |
| 23C. PHYSICIAN'S NAME (Type)
DR. JEROME COLLER | | 23D. ADDRESS
2217 SOUTH ROAD | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | 24B. DATE
10-31-67 | 24C. NAME OF CEMETERY OR CREMATORY
BALTIMORE HEBREW | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | 25B. NAME OF REGISTRAR
<i>Robert E. Farley, M.D.</i> | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|--|--|--|
| BIRTH NO. R-152 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10393 | |
| M.E. CASE NO. | | 67 10393 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | DORA ROBINSON | | 2. DATE AND HOUR OF DEATH
OCTOBER 30, 1967 9 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
5906 KEY AVENUE
00 | | A. STATE
MARYLAND | | B. COUNTY
BALTIMORE | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
27-20 | | | |
| | | D. STREET ADDRESS (If rural, give location)
5906 KEY AVENUE | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
FEBRUARY 15, 1904 | 9. AGE (In years last birthday)
63 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
CANADA | |
| 13. FATHER'S NAME
SOLOMON COHEN | | 14. MOTHER'S MAIDEN NAME
FANNIE EVANS | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NO | | 17. INFORMANT ADDRESS
MR. JULIUS ROBINSON, 5906 KEY AVENUE #21215 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
Carcinoma of Gall bladder | | INTERVAL BETWEEN ONSET AND DEATH
3 months | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO
None | | | |
| (B) DUE TO
None | | | | | |
| (C) DUE TO
None | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | None | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (was hospital) attended the deceased from July 21, 1967 to Oct 30, 1967 , that (I) (was) last saw the deceased alive on Oct 30, 1967 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Manuel Levin | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/30/67 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. MANUEL LEVIN | | 23D. ADDRESS
6101 PARK HEIGHTS AVENUE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-31-67 | | 24C. NAME OF CEMETERY or CREMATORY
HEBREW YOUNG MEN | |
| | | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD. | |

Greenwood & Bell House

100

100

100

100

100

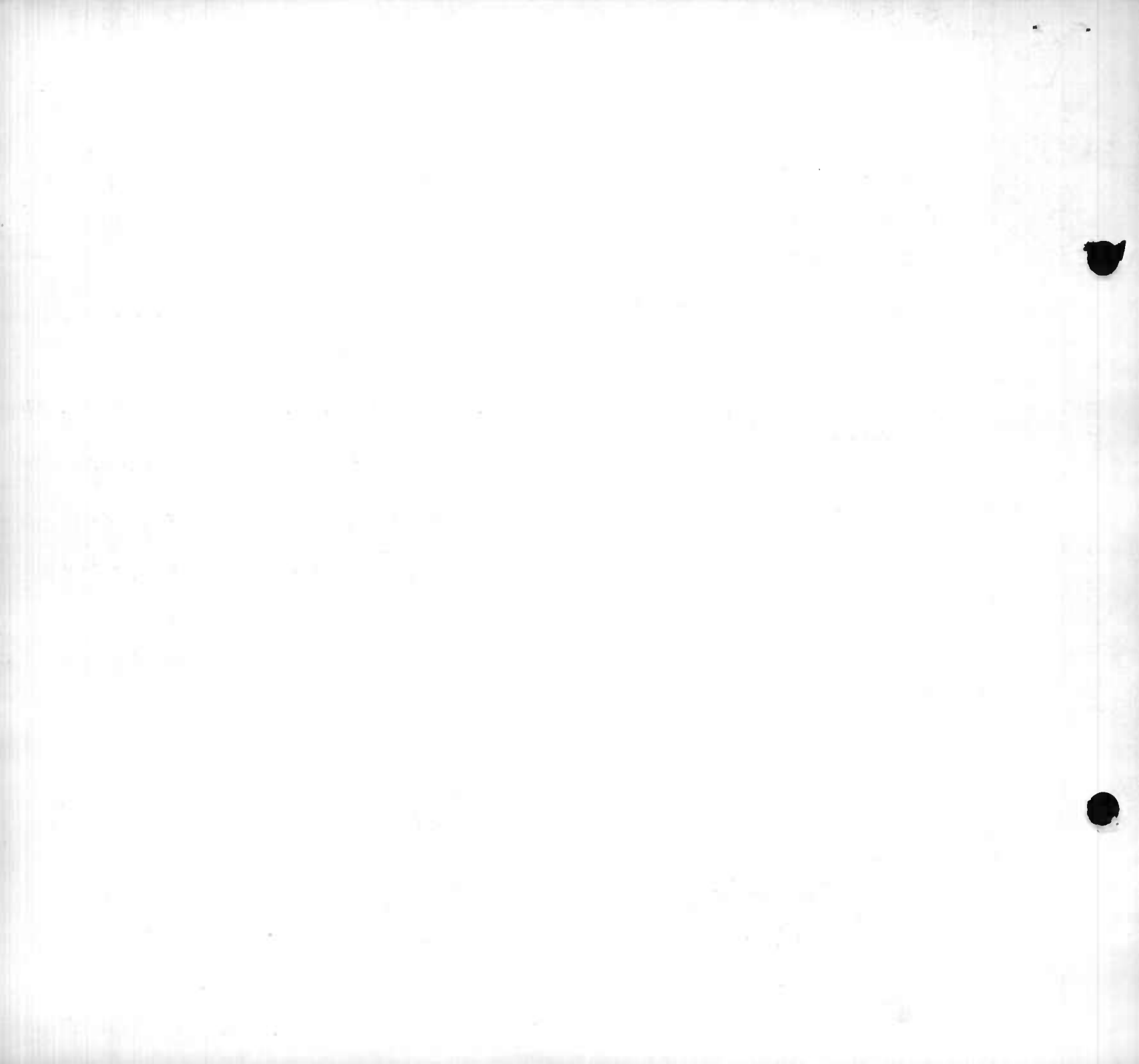
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|---|--|
| K-500
67 10384 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10394 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | |
| | | | | SADIE KOHN | |
| 2. DATE AND HOUR OF DEATH | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| OCTOBER 26, 1967 | | | | A. STATE
B. COUNTY | |
| 7 A.M. | | | | MARYLAND | |
| 5. SEX | | 6. RACE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FEMALE | | WHITE | | BALTIMORE | |
| 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | D. STREET ADDRESS (If rural, give location) | |
| WIDOW | | 70 | | 2906 WHITNEY AVENUE #21215 | |
| 9. AGE (In years
lost birthday) | | 10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| 70 | | HOUSEWIFE | | RUSSIA | |
| 12. CITIZEN OF
WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| U.S.A. | | SIGMUND LEBAUER | | TOBY ? | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL
SECURITY NO. | | 17. INFORMANT | |
| NO | | | | MR. DAVID SILVERBERG, 2624 A GATEHOUSE DR. #7 | |
| 18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, oshtenio, etc. It means the disease,
injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN
ONSET AND DEATH | |
| 420.1 I | | C. V. A. | | 1 day | |
| ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last. | | (B) DUE TO | | 5 years | |
| | | (C) Coronary Insufficiency | | 5 years | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | | 21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME
OF INJURY
(APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At <input type="checkbox"/> Not While
Work At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/20 19 47 to 10/26 19 67,
that (I) (we) last saw the deceased alive on 10/25 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| ISRAEL ZIMBERG | | | | 10/26/67 | |
| 23C. PHYSICIAN'S
NAME (Type) | | 23D. ADDRESS | | | |
| ISRAEL ZIMBERG | | 4000 W. NORTHERN PARKWAY | | | |
| 24A. BURIAL CREMATION,
REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 10-29-67 | | ADATH JESURUN | |
| 24D. LOCATION (City, town, or county) | | 24E. NAME of REGISTRAR | | 24F. FUNERAL DIRECTOR | |
| BALTIMORE, MARYLAND | | NOV 1 1967 | | SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| NOV 1 1967 | | Sol & E. Farberman | | SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

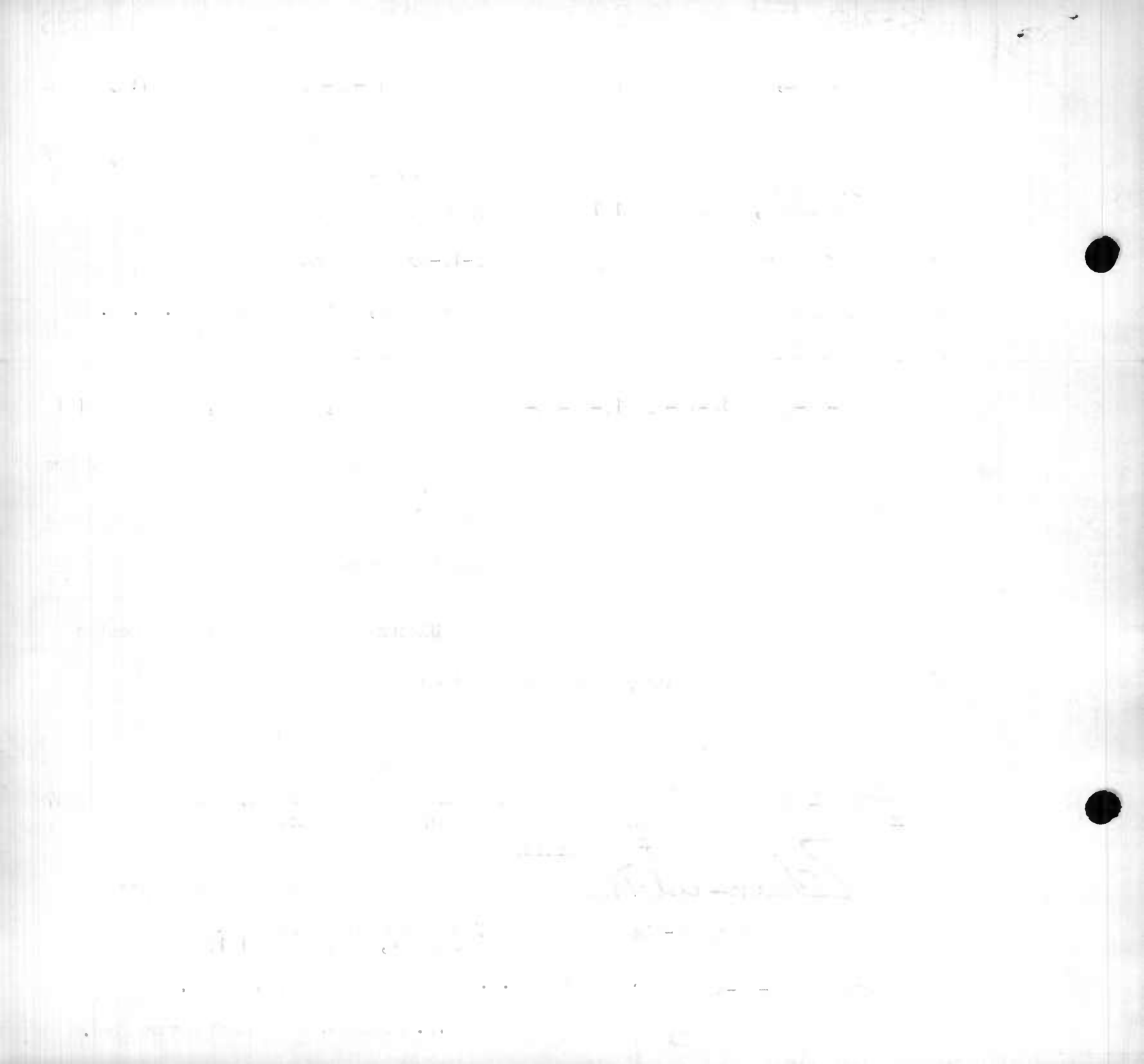
| BIRTH NO. 67 10395 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10395 | |
|--|--|--|--|---|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | | | Myrtle E. Hoover | | 10-28-1967 5:50 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | |
| 90 Gould Conv. Belair Road #6 | | | | Md. | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | D. STREET ADDRESS (If rural, give location) | | | |
| Baltimore | | | | 3306 Liberty Heights Avenue | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| Female | | Cau | | S | | 12-11-1874 | |
| 9. AGE (In years lost birthday) | | 10. AGE (In years lost birthday) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 92 | | 92 | | Maryland | | U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| Office | | | | U.S. Govt. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| John H. Hoover | | | | Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | | | 217-48-8500T | | Mrs Margaret I. Keithley 1414 Philadelphia | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| 422.11 Chronic myocarditis | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES | | | | 20 yrs | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Arteriosclerotic C-V disease | | | |
| II | | | | Cerebral arteriosclerosis & cerebral ischemia | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Malnutrition & associated Senility | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | X | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 6, 1967 to Oct. 28, 1967, that (I) last saw the deceased alive on October 27, 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| H.V. Harbold | | | | 10-30-67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| H.V. HARBOLD | | | | 4706 Harford Road Baltimore Maryland | | 21216 | |
| 24A. BURIAL-CREATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 10-31-1967 | | Woodlawn Cemetery | | Baltimore Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| NOV 1 1967 | | R. E. Fairbank | | Lassahn Funeral Home | | 7401 Belair Road | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|----------|--|---|--|-------------------------|--|
| K-252 | | 67 10396 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 87 10396 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) KOSHINSKI, Edward Eugene | | | | 10-29-67 1:25 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
27 VETERANS ADMINISTRATION HOSPITAL
3900 LOCH RAVEN BOULEVARD
BALTIMORE, MARYLAND 21218 | | | | A. STATE B. COUNTY
NEW JERSEY ATLANTIC | | | |
| 5. SEX
MALE | | | | 6. RACE
CAUCASION | | | |
| 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
NEVER MARRIED | | | | 8. DATE OF BIRTH
5-17-25 | | | |
| 9. AGE (In years last birthday)
42 | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CAMERA SALESMAN | | | |
| 11. BIRTHPLACE (State or foreign country)
GLEN LYON, PENNSYLVANIA | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
EDWARD KOSHINSKI | | | | 14. MOTHER'S MAIDEN NAME
MARTHA NOVAK | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES 6-28-43 TO 12-16-45 | | | | 16. SOCIAL SECURITY NO.
217-20-02-86 | | | |
| 17. INFORMANT
HOSPITAL RECORDS | | | | ADDRESS
VET ADMIN HOSP, BALTIMORE, MARYLAND 21218 | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Pulmonary Tuberculosis, Moderately Advanced, (Active)
INTERVAL BETWEEN ONSET AND DEATH
about 2 yrs | | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Diabetes Mellitus
about 2 yrs
Malabsorption Syndrome
2 yrs | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Decybutys Ulcers
months | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
RUL Resection for Tuberculosis | | | |
| 20A. AUTOPSY? (Yes or No)
YES | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
21D. TIME OF INJURY (APPROX.)
21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 8 APRIL 19 66 to 29 OCTOBER 19 67
that (X) (we) last saw the deceased alive on 29 OCTOBER 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Zaheer Ud-Din | | | | 23B. DATE SIGNED
10/30/67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
ZAHEER Ud-Din | | | | 23D. ADDRESS
3900 LOCH RAVEN BOULEVARD
BALTIMORE, MARYLAND 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | | | 24B. DATE
10-30-67 | | | |
| 24C. NAME OF CEMETERY or CREMATORY
St. Michaels R.C. | | | | 24D. LOCATION (City, town, or county) (State)
Glen Lyon, Penna. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | | |
| 25C. FUNERAL DIRECTOR
Wm. E. Johnson, 8521 Loch Raven Blvd. | | | | 25D. ADDRESS
22204 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10397 | |
| BIRTH NO. 67 10397 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH Oct. 27, 1967, 6 a. M. | |
| 1. NAME OF DECEASED (Type or Print) Durrett Stokes | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
90 Cranford Retreat Inc
2117 Denison St
21216 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2117 Denison St. | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 1881 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Artist | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 86 |
| 11. BIRTHPLACE (State or foreign country) ? | | 12. CITIZEN OF WHAT COUNTRY? 2 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME not known | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 220-12-8506 | 17. INFORMANT ADDRESS Marie G Foy 2117 Denison St. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
491X I
Bronchopneumonia | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) DUE TO
(B) DUE TO
(C) | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/1 1965 to 10/27 1967 , that (I) (we) lost saw the deceased alive on 10/26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Robert A. Reiter M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 10/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) Robert A. Reiter | | 23D. ADDRESS 606 Edmondson Ave. 21228 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 10/30/67 | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Farber | 25C. FUNERAL DIRECTOR ADDRESS Wm. J. Techner & Sons 21228 |

1971

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1971

1971

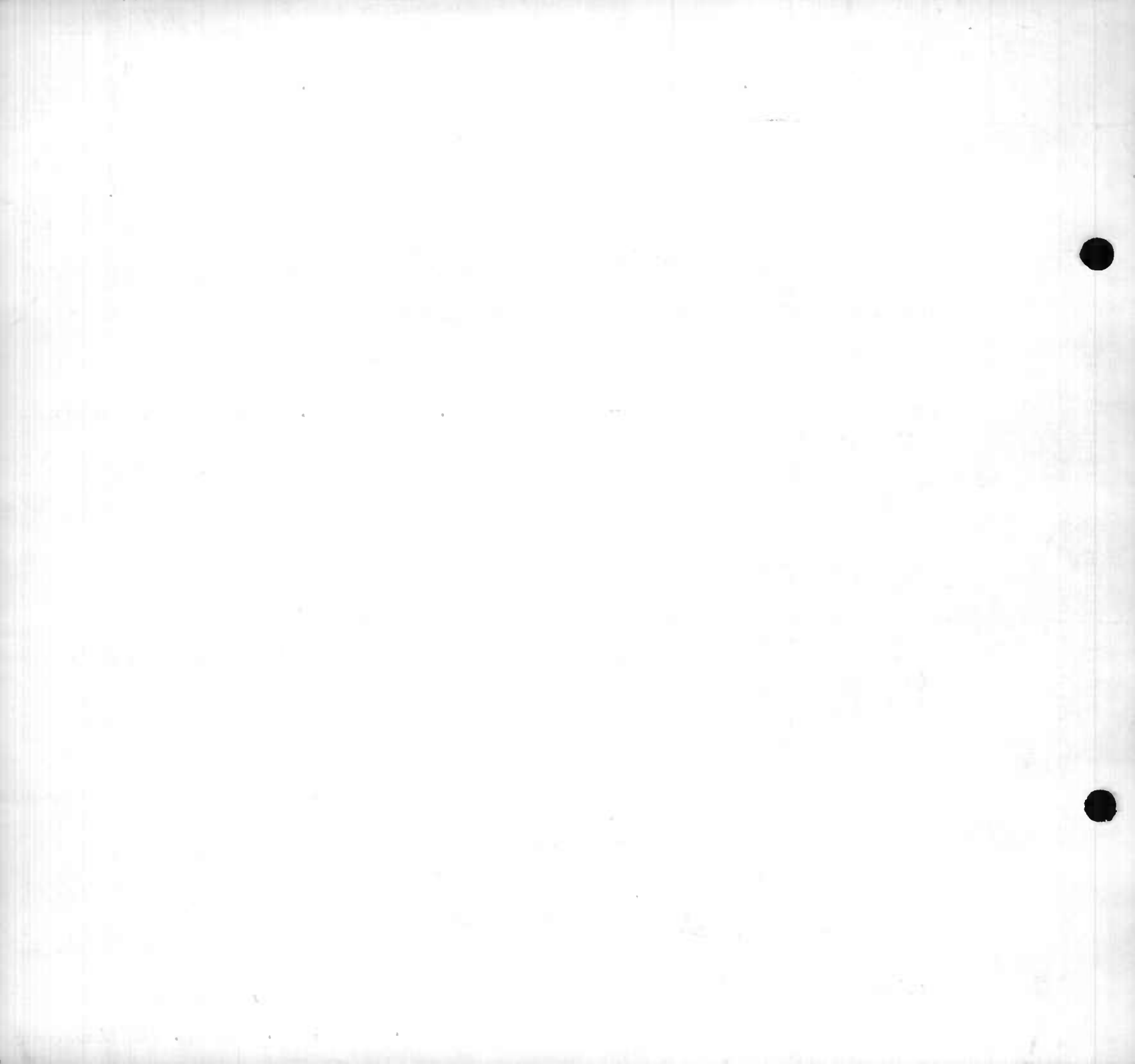
Robert A. Reiter

101

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 10398</u> | |
|---|---------------------|--|-------------------------------------|--|--|
| BIRTH NO. <u>67 10398</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Henry R. Gnau</u> | | 2. DATE AND HOUR OF DEATH
<u>Oct. 31, 1967</u> <u>6</u> A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE <u>Maryland</u>
B. COUNTY <u>Baltimore</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-10</u> | |
| <u>744 Belgian Avenue</u> | | D. STREET ADDRESS (If rural, give location) <u>744 Belgian Avenue</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>5/8/1902</u> | 9. AGE (In years last birthday)
<u>65</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Unclaimed freight Inspector B&O Railroad Baltimore, Maryland</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 13. FATHER'S NAME
<u>Adam Gnau</u> | | 14. MOTHER'S MAIDEN NAME
<u>Blanche Rowe</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>-</u> | | 17. INFORMANT
<u>Mrs. Beatrice K. Gnau</u> | |
| | | | | ADDRESS
<u>744 Belgian Ave</u> | |
| 18. <u>422.2 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>MYOCARDIAL DEGENERATION WITH ARTERIO SCLEROSIS</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
<u>YEARS</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>PULMONARY EMPHYSEMA</u> | | <u>YEARS</u> | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JULY 1</u> 19 <u>65</u> to <u>OCT 31</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>OCT. 28</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Luis J. Elias</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>OCT 31/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>LUIS J. ELIAS</u> | | 23D. ADDRESS
<u>1701 MERIDENE DR. BALTIMORE, MD.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>11/3/67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Holy Redeemer Cemetery</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>NOV 1 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Farber</u> | | 25C. FUNERAL DIRECTOR
<u>John A. Moran, Inc.</u> | |
| | | | | ADDRESS
<u>3000 E. Baltimore St</u> | |



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)(Charles Walter
CHARLES JOHNSON JOHNSON, Jr.)

2. DATE AND HOUR PRONOUNCED DEAD

October 30, 1967 9:42 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

33 Johns Hopkins Hospital D.O.A.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21230

D. STREET ADDRESS (If rural, give location)

1821 Belt Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

March 20 1906

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Apt. Complex

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Walter Johnson, Sr.

14. MOTHER'S MAIDEN NAME

Minnie Saltzers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-01-8693

17. INFORMANT

ADDRESS

Lucille Johnson, (Wife-Widow) (Same)

18.

E 902.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

In front of 1527 McElderry Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
10 30 67 9:3021E. INJURY OCCURRED
(WHILE AT WORK) ☒ ☐

21F. HOW DID INJURY OCCUR?

Subject fell from scaffold while painting a house

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

October 30, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Fri
Nov. 3 1967

23C. NAME OF CEMETERY or CREMATORY

Cedar Hill Cemetery

23D. LOCATION

(City, town, or county)

Brooklyn A A Co Md 21225

24A. DATE REC'D BY HEALTH DEPT.

NOV 1 1967

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

CURTIS E. EVANS

1400 S Charles St 21230

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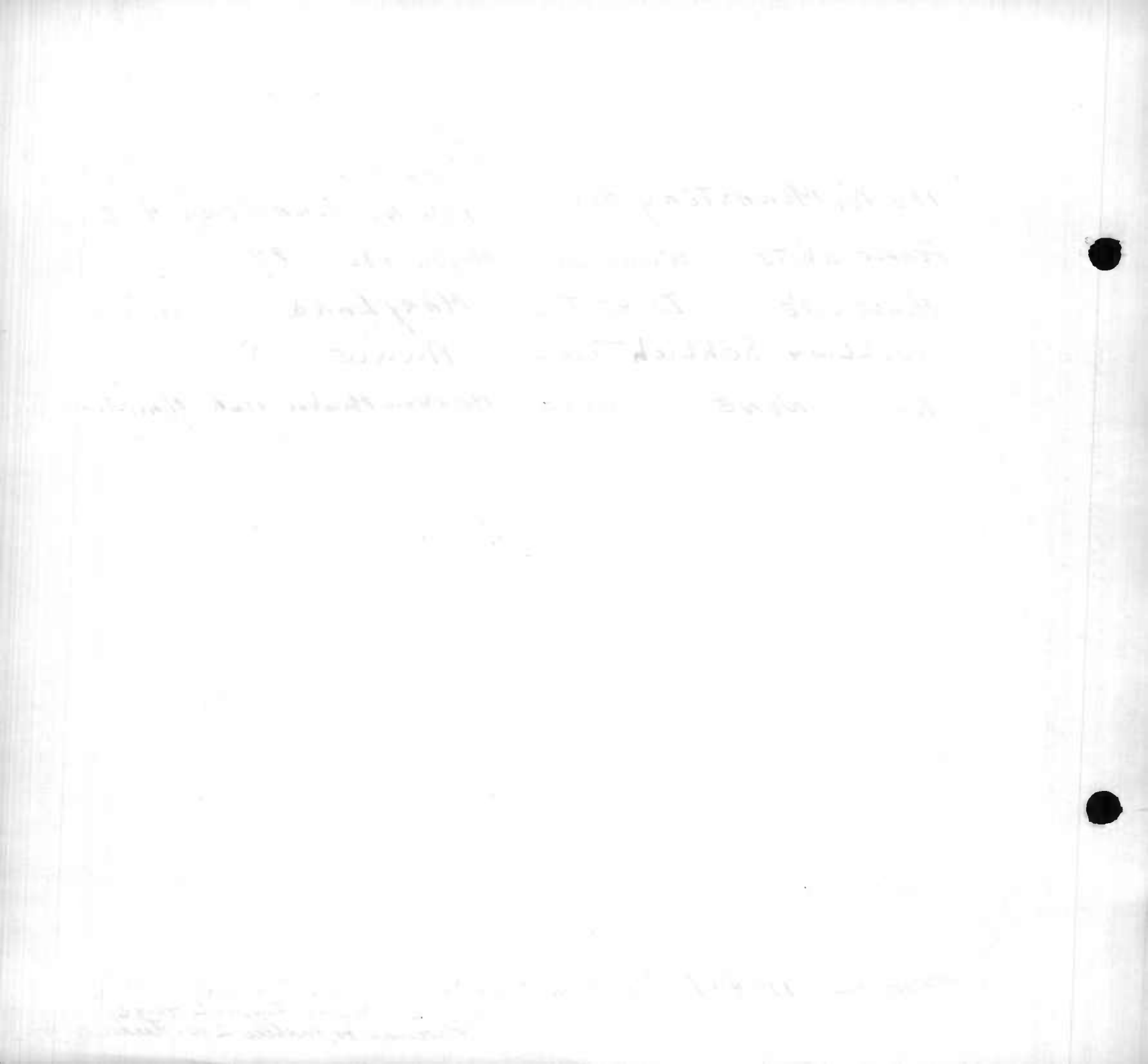
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| S-300 | | 67 10400 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10400 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | | |
| (Type or Print) | | | | Minnie M. Schotta | | | |
| 2. DATE AND HOUR OF DEATH | | | | October 31, 1967 2:45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| 00 | | 116 N. Monastery Ave | | Maryland | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 116 N. Monastery Ave | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| FEMALE | | White | | Widowed | | May 31, 1880 | |
| 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 87 | | Housewife | | Maryland | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| William Schlich Thorn | | | | Annie P | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | NONE | | Mrs. Marie Marchai | | 116 N. Monastery Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, oshterno, etc. It means the disease, injury or complication which caused death.) | | | | (A) Congestive Heart failure | | | |
| ANTECEDENT CAUSES | | | | (B) Diabetes mellitus | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Hypertension Arterio | | | |
| | | | | Sclerotic C.V. disease | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 22 1962 to Oct. 30 1967, that (I) (we) last saw the deceased alive on Oct. 31 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Albinas Klimas | | | | | | 11-1-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| ALBINAS KLIMAS | | | | 2030 Wilkerson Ave, Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 11-4-67 | | London Park | | Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | | |
| NOV 1 1967 | | Robert E. Fink | | 600 L. Schwab Funeral Home | | | |
| | | | | Thomas H. Spiller 2101 Frederick Ave | | | |



FUNERAL DIRECTOR: IMPORTANT MEDICAL EXAMINERS OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|-------------------------------------|--|---|
| BIRTH NO. 67 10401 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10401 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>McCoy, Elijah</i> | | 2. DATE AND HOUR OF DEATH
<i>10/28/67</i> <i>4:30 a.m.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>Baltimore</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Johns Hopkins Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<i>1032 N. Payson Street</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>N</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>8/2/1927</i> | 9. AGE (In years last birthday)
<i>40</i> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Mechanic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Buffalo, Ohi.</i> | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> |
| 13. FATHER'S NAME
<i>Elijah McCoy, Sr.</i> | | 14. MOTHER'S MAIDEN NAME
<i>Ethel Cooper</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Yes 1946-1966</i> | | 16. SOCIAL SECURITY NO.
<i>513-22-6059</i> | | 17. INFORMANT
<i>Mrs. Gertrude McCoy</i> | |
| 18. <i>331 X I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
<i>4 1/2 hr.</i> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Intracranial bleed</i>
DUE TO
<i>hemorrhage</i> | | | |
| ANTECEDENT CAUSES | | (B) <i>Vascular lesion</i>
DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<i>No</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/28</i> <i>1967</i> to <i>10/28</i> <i>1967</i> , that (I) (we) lost saw the deceased alive on <i>10/28</i> <i>1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>A. B. Einstein Jr.</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>10/28/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>A. B. EINSTEIN, Jr.</i> | | M.D. | | 23D. ADDRESS
<i>Johns Hopkins Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11-6-67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Ft. Gibson NAT. Cemetery</i> | |
| 24D. LOCATION
<i>OKA/home</i> | | 24E. LOCATION (City, town, county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>NOV 1 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>MORTON + Dyett</i> | |
| | | | | ADDRESS
<i>1701 LAURENS</i> | |

1032 W. Park Street
Boston
Mass

USA

8/2/92 40
Butt of Off.
C. J. Cooper

Vascular lesion
hemorrhage
intracranial

Yes

Johns Hopkins Hospital
M N
Marrow

2
Bluish M. 1946-1948

Yes 1946-1948

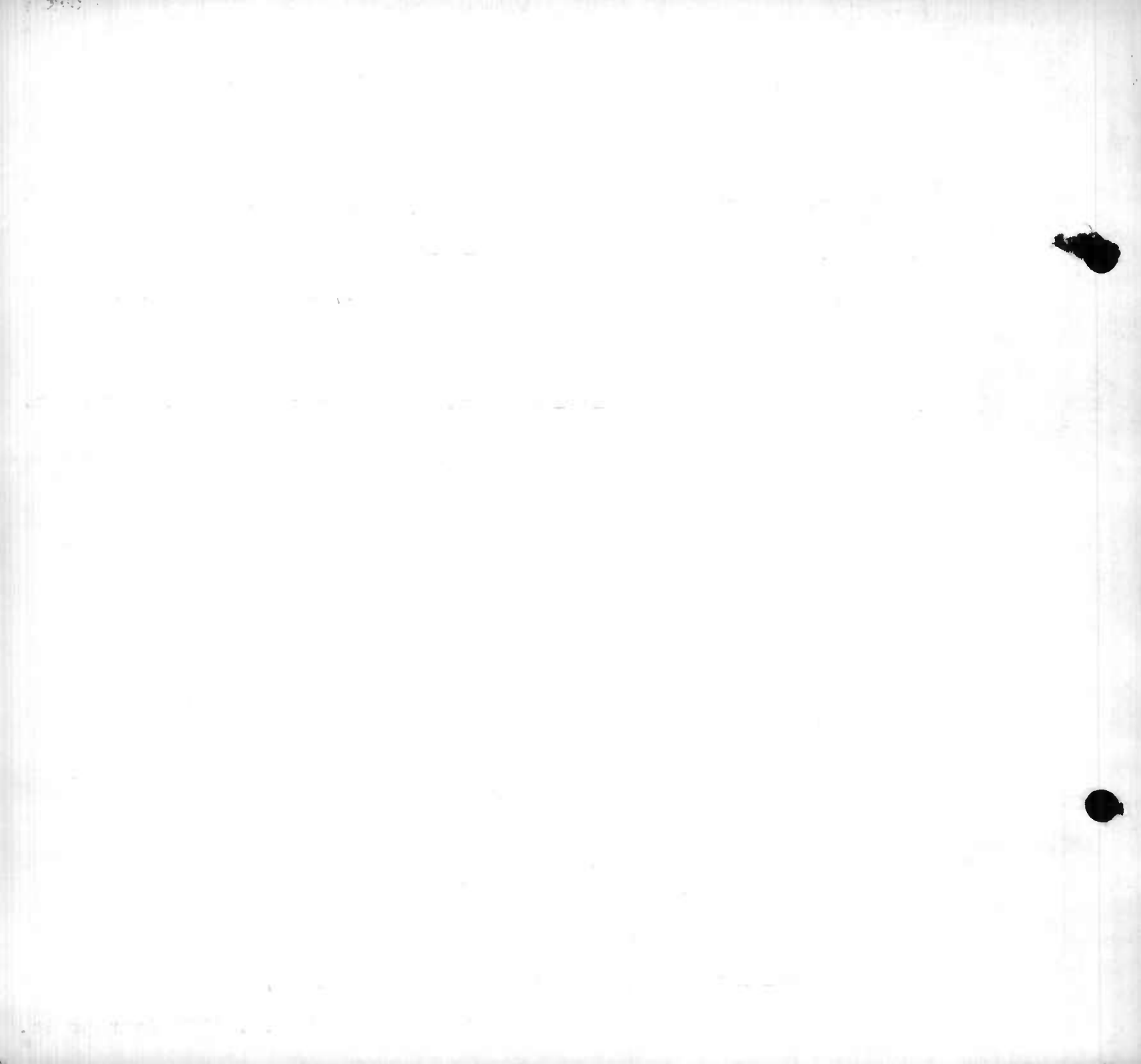
No

A. B. Einstein, Jr.
10/32 1932 1932 1932
Johns Hopkins Hospital
10/32/1932

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|---|--|
| W-237
67 10402 | | BALTIMORE CITY HEALTH DEPARTMENT
67 10402 | |
| BIRTH NO.
M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| SALLIE MAY WESTBROOK | | Oct. 29, 1967 6:00 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
B. COUNTY | |
| 90 KENSON
2922 Arunah Avenue | | MARYLAND | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location) | |
| | | 1606 N. Monroe Street | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| F. | N. | WIDOWED | 7-25-1901 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years lost birthday) | 11. BIRTHPLACE (State or foreign country) |
| HOUSEWIFE | HOME | 66 | HALIFAX CO., VIRGINIA |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | 12. CITIZEN OF WHAT COUNTRY? | |
| EDGAR SCOTT | SISSIE SCOTT | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
| NO. | 224-01-0113 | Mr. John Foster | 1606 N. Monroe St. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | (A) Chronic Cardio-Vascular Disease | | Several Months |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 0 NONE | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 15, 1967 to Oct. 29, 1967, that (I) (we) last saw the deceased alive on Oct. 29, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Frank N. O'Brien | | | 23B. DATE SIGNED
Oct. 31, 67 |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| Frank N. O'Brien | | 2701 N. Calvert St. Balto. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
| BURIAL | 11-1-67 | MOUNT CALVARY CEM. | A.A.CO., MARYLAND |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | ADDRESS |
| NOV 1 1967 | Robert E. Taylor | MORTON & DYETT F.H. | 1701 Laurens St. |



| BIRTH NO. | | M.E. CASE NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
|---|-------------------------|---|---|---|---|---|--|
| J-250 | | 67 10403 | | BALTIMORE CITY HEALTH DEPARTMENT | | 67 10403 | |
| 1. NAME OF DECEASED
(Type or Print)
NANNIE JACKSON | | | | 2. DATE AND HOUR PRONOUNCED DEAD
October 31, 1967 2:00 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
2535 Pennsylvania Avenue | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2535 Pennsylvania Avenue | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
4-6-1894 | 9. AGE (In years last birthday)
73 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
MECHLINBURG CO., VA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
ABRAHAM LEE | | | 14. MOTHER'S MAIDEN NAME
SALLIE WHITE | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown), (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
213-34-5630 | 17. INFORMANT
Mrs. Nannette Jackson | | ADDRESS
2535 Penna. Ave | | |
| 18. 422.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz, M.D.
EXAMINER'S NAME (Type) | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
11-3-67 | | 23C. NAME of CEMETERY or CREMATORY
Arbutus Memorial Pk. | | 23D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 24B. NAME OF REGISTRAR
Robert E. Taylor, Jr. | | 24C. FUNERAL DIRECTOR ADDRESS
MORTON & DYETT F.H. 1701 Laurens St. | | | |

24 JUL 68

RECEIVED

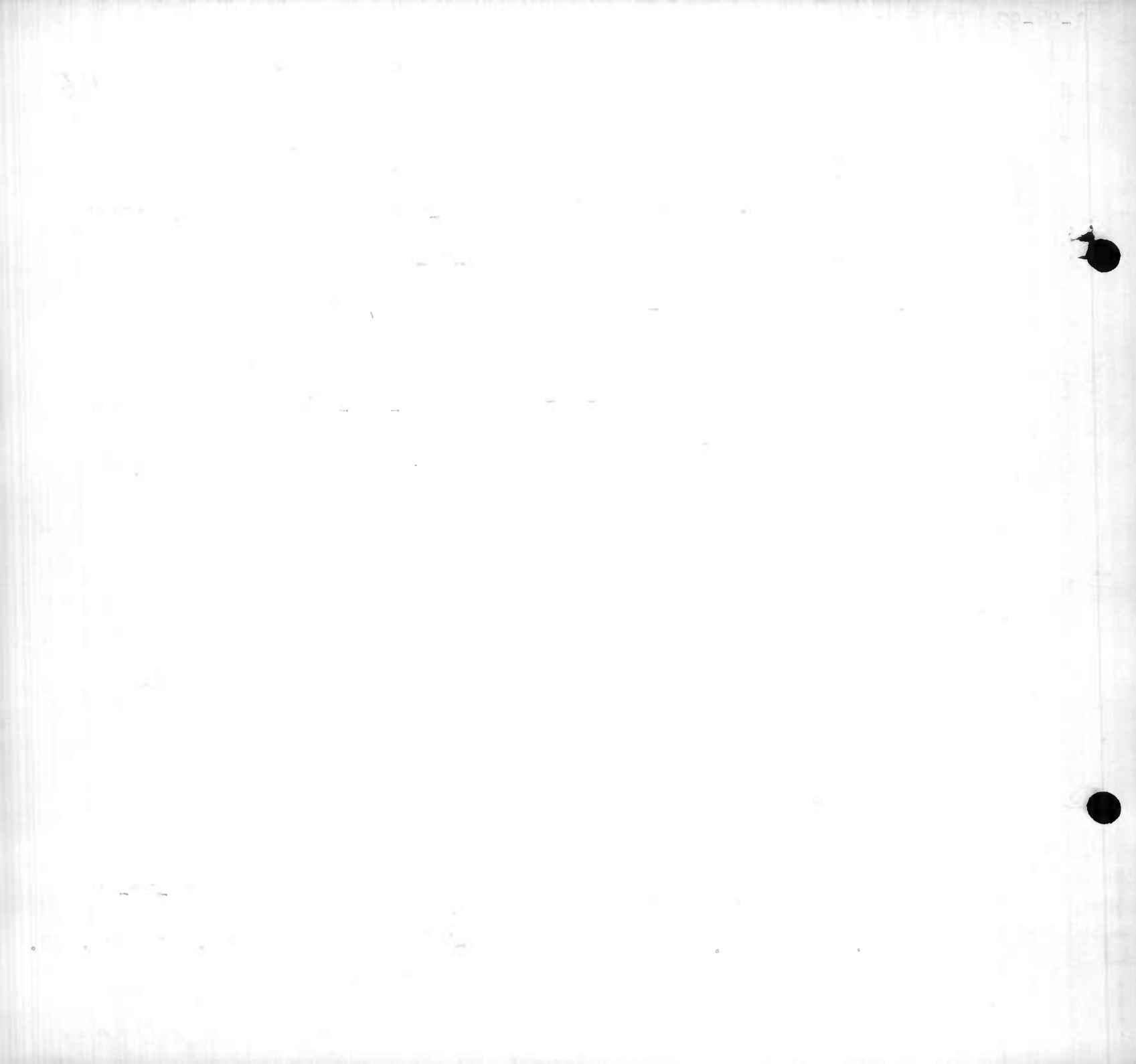
RECEIVED

31-74-921

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|-----------------------------|--|--|
| BIRTH NO. 67 10404 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10404 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) JAMES RICHARDSON | | 2. DATE AND HOUR OF DEATH
10/30/67 3:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 26-12 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | D. STREET ADDRESS (If rural, give location)
BCH-4940 EASTERN AVENUE, # 21224 | | | |
| 5. SEX
MALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
5-30-09 | 9. AGE (In years lost birthday)
58 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY
BETH-STEEL | | 11. BIRTHPLACE (State or foreign country)
MARYLAND, Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
JOHN THOMAS | | 14. MOTHER'S MAIDEN NAME
GEOGIANNA COTTON | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
217-03-6586 | | 17. INFORMANT
RECORDS-BCH-4940 EASTERN AVENUE | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Multiple CVA's unknown | | (A) DUE TO
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
6 YRS. | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (4) (this hospital) attended the deceased from OCT. 29 5/19 19 62 to OCT. 29 19 67, that (I) (we) last saw the deceased alive on OCT. 29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Raymond J. LaSore M.D. | | | | 23B. DATE SIGNED
10-30-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
DR. RAYMOND J. LA SURE M.D. BCH-4940 EASTERN AVENUE, BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
NOV 1 1967 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Md. | |
| 24D. LOCATION
Arbutus Md. | | 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairley M.D. | |
| 25C. FUNERAL DIRECTOR
MORTON & Dyett | | 25D. ADDRESS
1701 LANCERS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10405 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10405 | |
|--|---------------------|---|------------------------------------|--|----------------------------|---|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Albert Brown</u> | | | | 2. DATE AND HOUR OF DEATH
<u>10/30/67</u> <u>13:50 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>Monzeballo State Hosp.</u> | | | | A. STATE <u>BALTO.</u>
B. COUNTY <u>BALTO.</u> | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTO.</u> | | | | D. STREET ADDRESS (If rural, give location)
<u>1538 Leslie St.</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>N</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>M</u> | 8. DATE OF BIRTH
<u>4/10/13</u> | 9. AGE (In years lost birthday)
<u>54</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Waiter</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Restaurant</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Unknown - Moses Brown</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Kate Brown</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>228-01-3329</u> | | 17. INFORMANT
<u>Mrs. Julia Brown</u> | |
| | | | | ADDRESS
<u>1538 Leslie Ct.</u> | | | |
| 18. <u>443X1</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <u>Uremia</u>
DUE TO
(B) <u>Vascular Hypertension</u>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 yrs</u>
<u>Unknown (many)</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Congestive Heart Failure</u> | | | | | | <u>4 yrs</u> | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8/8</u> <u>1967</u> to <u>10/30</u> <u>1967</u> , that <input checked="" type="checkbox"/> (I) <u>last</u> saw the deceased alive on <u>10/30</u> <u>1967</u> and that in (my) <u>(my)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(did)</u> <u>(did not)</u> view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>[Signature]</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>10/30/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | M.D. | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>11-4-67</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>ARBUTUS</u> | | 24D. LOCATION (City, town, or county) (State)
<u>BALTO.</u> <u>Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>NOV 1 1967</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>MORTON + Dyer</u> | | ADDRESS
<u>1701 LAWRENS</u> | |

| BIRTH NO. | | M.E. CASE NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
|---|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| CHARLES T. SMITH, Jr. | | October 28, 1967 9:22 P.M. | | FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
Maryland | |
| 2428 Lakeview Avenue | | Baltimore | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | B. COUNTY | |
| 5. SEX
Male | | 6. RACE
Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
12-4-1947 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 9. AGE (in years last birthday)
19 | |
| RUBBER CO. | | BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
CHARLES SMITH, SR. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | | | Mrs. Peggie L. Smith | | 2428 Lakeview | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Sickle Cell Disease | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) DUE TO | | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (B) DUE TO | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| | | (C) DUE TO | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | BURIAL | | 10-3-67 | | Arbutus Memorial Pk. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | 24D. LOCATION (City, town, or county) (State) | |
| NOV 1 1967 | | Robert E. Finkbeiner | | MORTON & DYETT F.H. | | 1701 Laurens St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|-------------------------|---|--|--|--|--|--|
| BIRTH NO. P-624 | | 67 10407 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10407 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) Purcell - Edward | | | | 2. DATE AND HOUR OF DEATH
5.30 am 10-30-1967 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

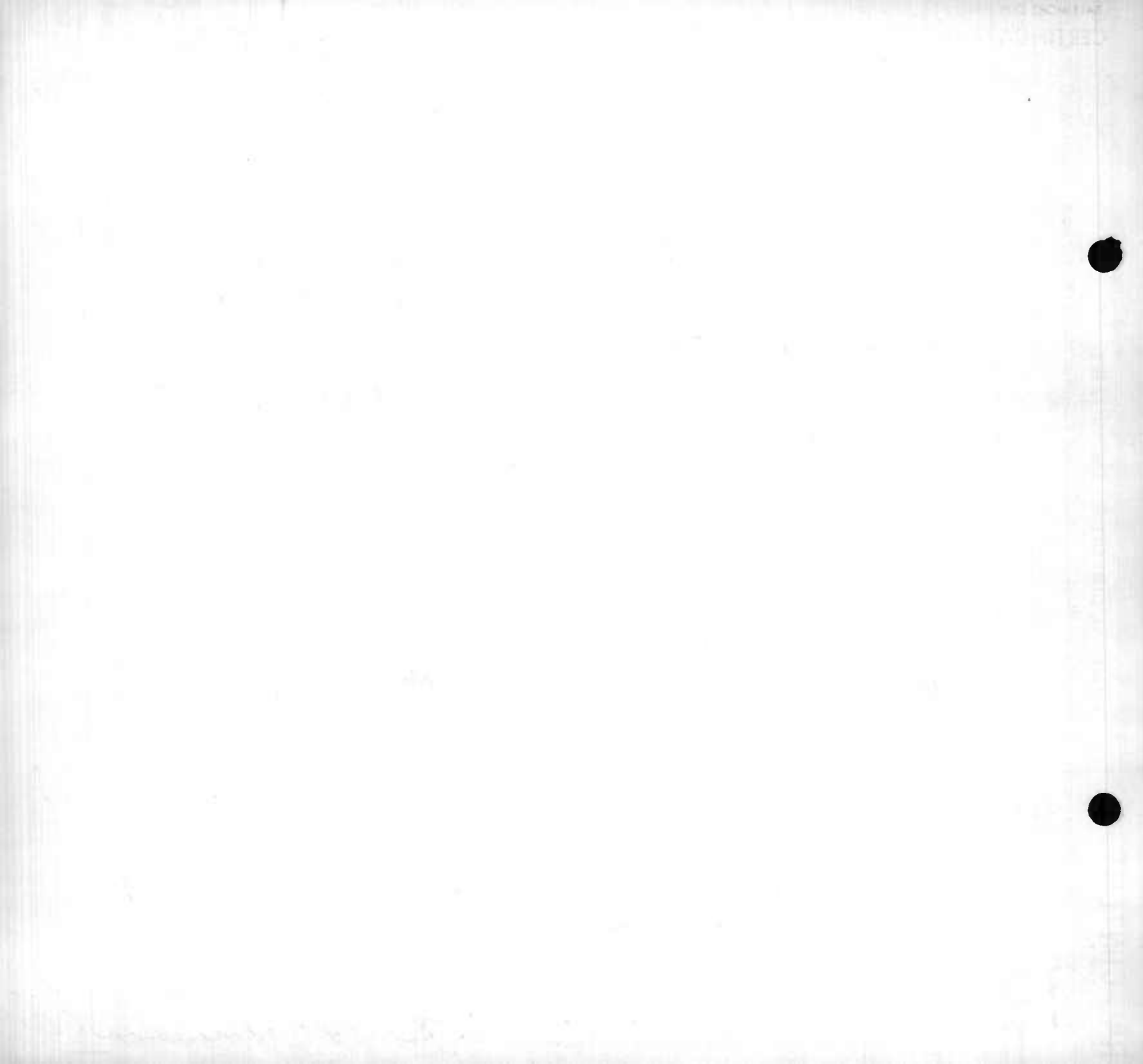
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
48 Maryland General Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 4-01
D. STREET ADDRESS (If rural, give location) 111 W. Mulberry St | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced | 8. DATE OF BIRTH
8/5/90
08, 05, 90 | 9. AGE (In years lost birthday)
77 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
WASHINGTON | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
----- | | | | 14. MOTHER'S MAIDEN NAME
----- | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
085 12 8580 | | 17. INFORMANT
Jack N. Tribby
109 N. Rock Glen Rd. | | ADDRESS | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Antecedent Causes
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) Cerebral Hemorrhage, ducts
DUE TO
(B) Arteriosclerotic cardiovascular disease.
DUE TO
(C) diabetes mellitus. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-26-1967 to 10-30-1967 , that (I) (we) last saw the deceased alive on 10-30-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Oyus Makou | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10-30-67 | |
| 23C. PHYSICIAN'S NAME (Type) eyrus Makou | | | | 23D. ADDRESS
Maryland Gen. Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/3/67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairbank | | 25C. FUNERAL DIRECTOR
Witzke F. D. | | ADDRESS
- 4101 Edmondson Ave. | |

WASHINGTON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 10408 | | Registered No. 67 10408 | |
|--|-------------------------|---|--|--|--|--|--|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) CLAYTON - BERNADINA | | 2. DATE AND HOUR OF DEATH
10/31/67 5-35 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
LUTHERAN HOSPITAL OF MARYLAND | | (If not in hospital or institution, give street address or location) | | A. STATE
MARYLAND | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE MARYLAND 28-04 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
4627 OLD FREDERICK ROAD | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
<input checked="" type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)
WIDOWED | | 8. DATE OF BIRTH
4-5-87 | 9. AGE (In years lost birthday)
80 years | If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND OHIO | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HENRY WILKER | | | | 14. MOTHER'S MAIDEN NAME
--- | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
WILLIAM T. DIXON Jr. | | ADDRESS
Old Frederick Rd. | |
| 18. 443X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) ASHCVD
DUE TO
(B) CEREBRO VASCULAR ACCIDENT
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>10-28</u> 19 <u>67</u> to <u>10-31</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-31</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
V. Biswanath Pillai | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/31/67 | |
| 23C. PHYSICIAN'S NAME (Type)
V. BISWANATH PILLAI | | | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-2-67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore Nat. Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
Walter F. D-4101 | | ADDRESS
Edmondson Cr. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|---|-----------------------------------|---|--|
| BIRTH NO. 67 10409 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10409 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MARIE A. BROWN | | 2. DATE AND HOUR OF DEATH
10/30/67 9:25 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
37 Mercy Hosp.
301 ST. PAUL PLACE | | A. STATE
Maryland | | B. COUNTY
Baltimore | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 28-04 | | | |
| | | D. STREET ADDRESS (If rural, give location)
616 Cooks Lane, Apt. 101 | | | |
| 5. SEX
F | 6. RACE
Caucasian | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
7-9-96 | 9. AGE (In years last birthday)
71 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore City | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Phillip Hendricks | | 14. MOTHER'S MAIDEN NAME
Lydia Ellsworth | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Charles H. Brown
616 Cooks Lane - 21229 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
420.101.260X | | CAUSE OF DEATH
Cardiac Arrest | | INTERVAL BETWEEN ONSET AND DEATH
seconds | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO
Acute Coronary Thrombosis hrs. | | (B) DUE TO
Arteriosclerotic Heart Disease yrs. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus | | | | yes. | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
yes. | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/10 19 67 to 10/30 19 67 , that (I) (we) last saw the deceased alive on 10/30/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Jean M. H. Horne | | | | 23B. DATE SIGNED
10/30/67 | |
| 23C. PHYSICIAN'S NAME (Type)
M.D. | | | | 23D. ADDRESS
Mercy Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-2-67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National - Baltimore, Md. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jankins | |
| 25C. FUNERAL DIRECTOR
Whitney T. D. - 4101 Edmondson | | 25D. ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY DEPARTMENT | | | | BIRTH NO. 67 10410 | | CERTIFICATE OF DEATH | | Registered No. 67 10410 | |
|---|--|--|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) Marvin Miller | | | | 2. DATE AND HOUR OF DEATH
October 20, 1967 | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

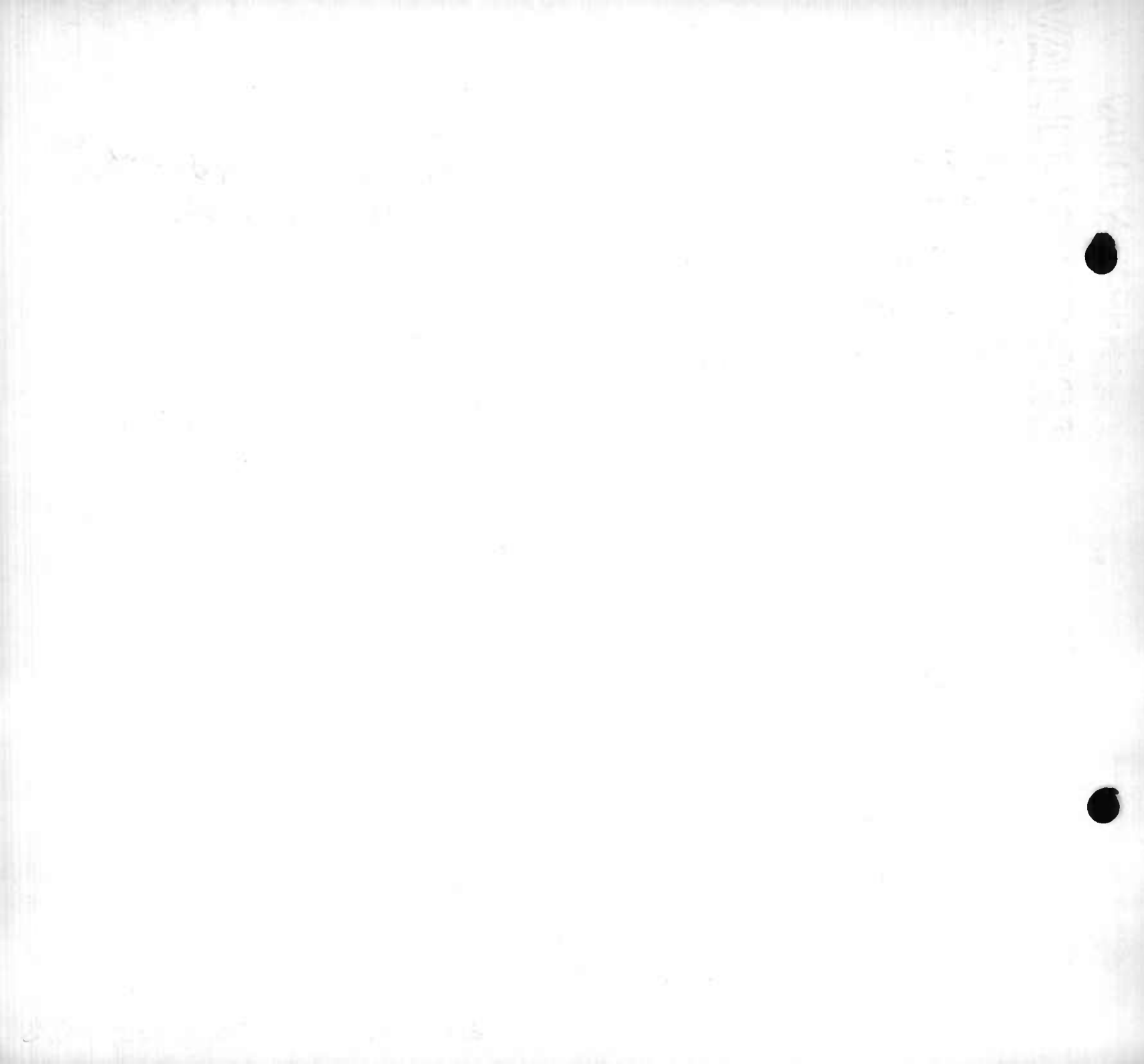
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2005 Oak Drive | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2005 Oak Drive | | | | | |
| 5. SEX
Male | | 6. RACE
White | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | | 8. DATE OF BIRTH
August 5, 1890 | | 9. AGE (In years last birthday)
77 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
213-09-6160 | | 17. INFORMANT
Ruth Baer - Same | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)
750.01
Supra-tension of Age
Regenerative Brain Syndrome
Chronic Coronary | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1967 to Oct 20 1967 , that (I) (we) last saw the deceased alive on Oct 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Dr. Thomas J. Roberts | | | | 23B. DATE SIGNED
10-27-67 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. 4509 Liberty Heights Ave. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-23-67 | | 24C. NAME of CEMETERY or CREMATORY
Lorraine Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
Ellsworth Armacost | | | |
| ADDRESS
4600 Liberty Hgts Ave. | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--|--|--|--|--|
| BIRTH NO. | | 67 10411 | | 67 10411 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| ROSARIA GARIBALDI | | 10-29-67 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| House In The Pines-Belvedere | | MD | | BALTIMORE | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | |
| Female | | White | | Widowed | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| At Home | | | | 7-19-1876 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| Stephen Tamburo | | — | | 91 | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 11. BIRTHPLACE (State or foreign country) | |
| — | | — | | ITALY | |
| 17. INFORMANT | | ADDRESS | | 12. CITIZEN OF WHAT COUNTRY? | |
| Antonio Ferrara | | 3611 N. Rogers Ave | | ITALY | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| Adeno-carcinoma of uterus | | | | 9 mo. | |
| Antecedent Causes | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | 6 mo. | |
| | | | | 5 yrs. | |
| II | | Generalized Arterio Sclerosis | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| None | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (third party) attended the deceased from 4/12 1966 to 10/29/1967 that (I) (we) last saw the deceased alive on 10/28/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Earl L. Chambers | | | | 10/30/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Earl L. Chambers | | | | 4108 Liberty St Balto Md | |
| 24A. BURIAL REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 11-2-67 | | Holy Redeemer Cmn | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| NOV 1 1967 | | Robert E. Falsano | | Ellsworth Armacost-4600 Liberty Hgts | |



1
T-260

BIRTH NO. 61-10050 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) LINDA Rose TUCKER 2. DATE AND HOUR PRONOUNCED DEAD October 31, 1967 8:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY _____

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI HOSPITAL (DOA)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
5630 Stonington Avenue

5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE 8. DATE OF BIRTH APRIL 6, 1961 9. AGE (in years last birthday) 6 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 10B. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) Baltimore, Md 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME HARRY M. TUCKER 14. MOTHER'S MAIDEN NAME BARBARA CONKLIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) - 16. SOCIAL SECURITY NO. - 17. INFORMANT HARRY M. TUCKER - Same ADDRESS _____

18. E812.41 CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Injuries
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) _____
DUE TO
(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION 10/31/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Gwynn Oak and Silver Hill Aves.

21D. TIME OF INJURY (APPROX.) 10/31/67 8:20 A. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? Pedestrian in auto-auto collision

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 10/31/67
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 23B. DATE 11-3-67 23C. NAME of CEMETERY or CREMATORY Baltimore National 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT. NOV 1 1967 24B. NAME OF REGISTRAR Robert E. Fisher 24C. FUNERAL DIRECTOR ADDRESS Elkworth Armacost - 4600 Liberty Heights

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 67 10413 | |
|---|------------------|--|--|---|---|
| BIRTH NO. 67 10413 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Gruswald Lottie M.</i> | | 2. DATE AND HOUR OF DEATH
<i>10/30/67 8:40 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>48 Maryland General Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>2</i> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore 28-41</i> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<i>4404 Fernhill Ave.</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH
<i>05/24/01</i> | 9. AGE (In years lost birthday)
<i>66 yrs.</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Mail Clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Reliable Stores, Inc.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Md.</i> | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S. of A.</i> |
| 13. FATHER'S NAME
<i>Ernest Frank</i> | | 14. MOTHER'S MAIDEN NAME
<i>Kate Miller</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>0</i> | | 16. SOCIAL SECURITY NO.
<i>219-16-2837</i> | | 17. INFORMANT
<i>Chas. Arthur G. Gruswald - Same</i> | |
| 18. <i>199.21</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshterio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>Carcinomatosis</i>
DUE TO

(B) <i>—</i>
DUE TO

(C) <i>—</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>?</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

II | | | | | |
| 19A. DATE OF OPERATION
<i>8/12/67</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Exploration</i> | | 20A. AUTOPSY? (Yes or No)
<i>?</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/27/67</i> 19 to <i>10/30/67</i> 19, that (I) (we) last saw the deceased alive on <i>10/30/67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>James O. Burk</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>10/30/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
<i>Maryland General Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11-3-67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Druid Ridge Cemetery</i> | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>NOV 1 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Tardner</i> | | 25C. FUNERAL DIRECTOR
<i>Ellsworth Armbrust - 4600 Liberty Heights</i> | |
| | | | | ADDRESS | |

and a small box
of paper

10

from the
North West
County

One copy

2

10 copies

4

10

10

10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10414

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES

WALKER

2. DATE AND HOUR PRONOUNCED DEAD

October 30, 1967

5:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

921 Bevan Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

921 Bevan St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

W

8. DATE OF BIRTH

7-4-1898

9. AGE (In years
last birthday)

69

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

I

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

B-W-I.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Victoria Allen-157 W. Hamburg Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
m. WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

10/31/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

II-3-67

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Ct

23D. LOCATION

(City, town, or county)

Baltimore City

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 1 1967

Robert E. Farley, M.D.

Isaiah L. Brown Son

108 W. Montgomery Street

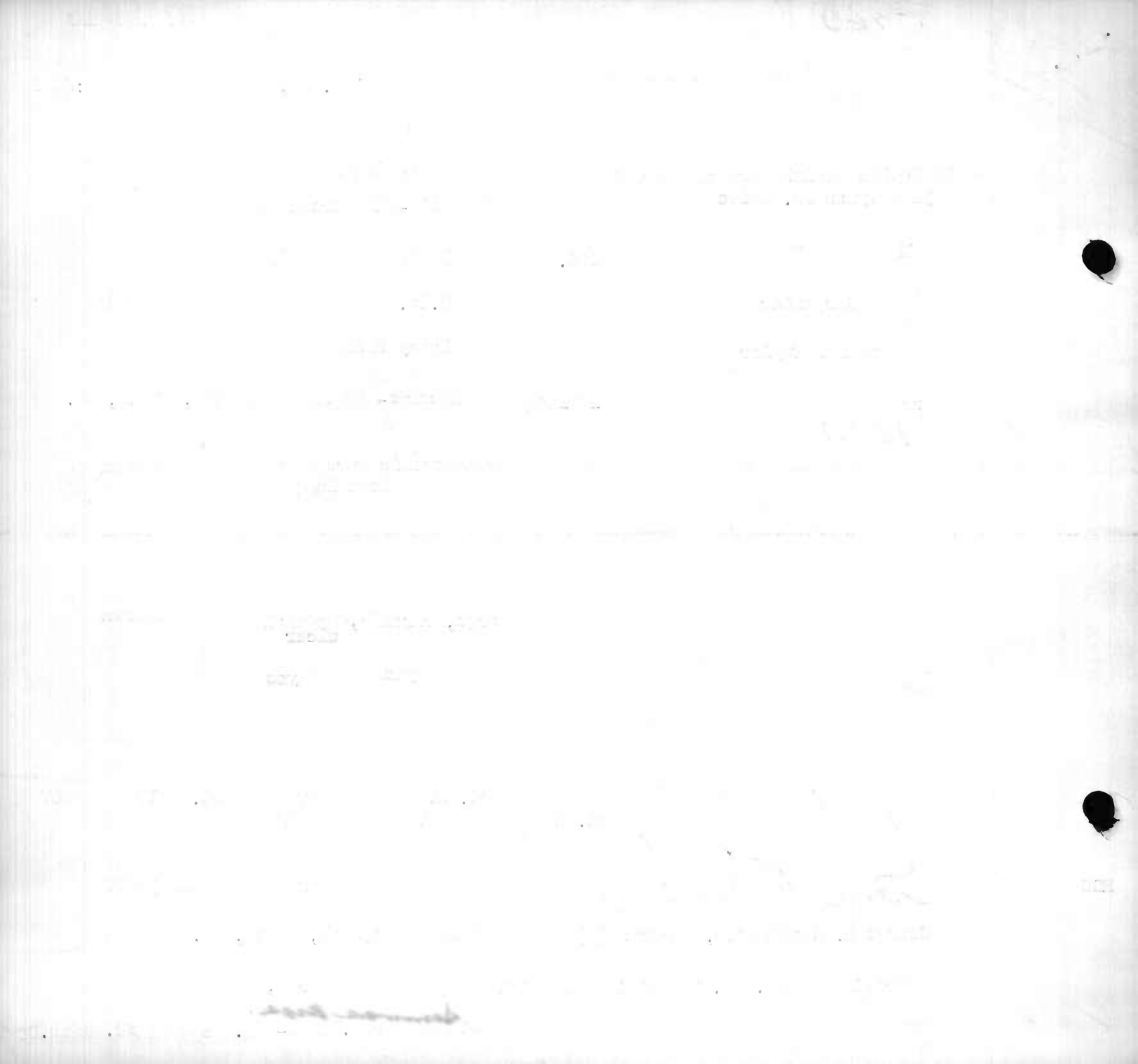
I

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|------------------------------------|--|--|
| BIRTH NO. 7-460 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10415 | |
| M.E. CASE NO. | | 67 10415 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) George Dewey Taylor | | 2. DATE AND HOUR OF DEATH
Oct. 29, 1967 | | 8:40 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
3100 Wyman Pk. Drive | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE DC
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Washington
D. STREET ADDRESS (If rural, give location)
226-5th Street SE | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Wid. | 8. DATE OF BIRTH
9/30/98 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
W. Va. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Sampson Taylor | | 14. MOTHER'S MAIDEN NAME
Nancy Hill | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
579-01-2249 | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
162.1 I
Bronchogenic carcinoma left lung | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
Unknown | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Large, chronic, duodenal ulcer | | Unknown | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 17 19 67 to Oct. 29 19 67 , that (I) (we) last saw the deceased alive on Oct. 29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>George H. Greidinger</i> | | | | 23B. DATE SIGNED
10/30/67 | |
| 23C. PHYSICIAN'S NAME (Type)
George H. Greidinger, Surgeon (R) | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Nov. 1st. 67 | | 24C. NAME OF CEMETERY or CREMATORY
Trinity Memorial Gardens | |
| 24D. LOCATION (City, town, or county) (State)
Waldorf, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Simmons Bros. | | ADDRESS
1661- Gd. Hope Rd SE. Wash. DC | |



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EARL STINEBAUGH

2. DATE AND HOUR PRONOUNCED DEAD

October 29, 1967 4:19 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

43
99 South Baltimore General Hospital
D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

West Virginia

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Great Cacapon

D. STREET ADDRESS (If rural, give location)

Cacapon
Great Cacapon, West Virginia

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4/10/23

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Aircraft

10B. KIND OF BUSINESS OR INDUSTRY

Manf.

11. BIRTHPLACE (State or foreign country)

W.Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John S. Stienbaugh

14. MOTHER'S MAIDEN NAME

Pansey Farris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW 2

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

Family Record

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Tunnel

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Harbor Tunnel Thruway & Exit 4b (Richie

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

10 29 67 3:58

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject driver in auto-fixed object coll. Hwy.)

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 30, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

11/2/67

23C. NAME of CEMETERY or CREMATORY

Behnel

23D. LOCATION

Berkley Spring W.Va

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 1 1967

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

John R. Slack

ADDRESS

Edgewater City

100

100

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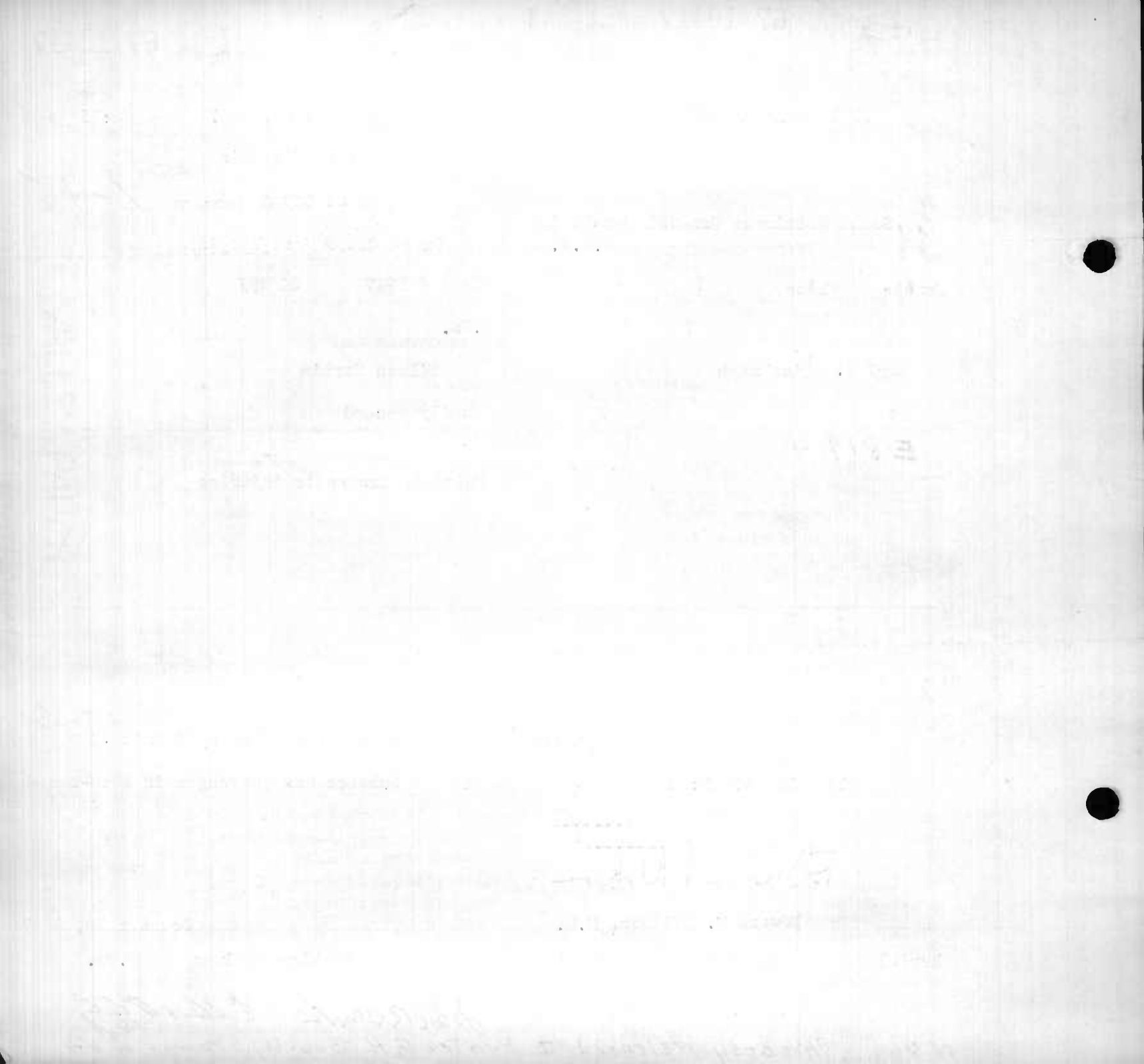
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| BIRTH NO. | | 67 10417 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. 67 10417 | | |
|--|--|-------------------------|-------------------------------------|--|---|---|---|---|--|--|
| M.E. CASE NO. | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
JUDY STINEBAUGH | | | | | 2. DATE AND HOUR PRONOUNCED DEAD
October 29, 1967 4:35 PM. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

South Baltimore General Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE West Virginia
B. COUNTY Cacapon
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Great Cacapon
D. STREET ADDRESS (If rural, give location) Great Cacapon West Virginia | | | | | |
| 5. SEX
Female | | 6. RACE
White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
? | | 8. DATE OF BIRTH
Sept 6 1947 | | 9. AGE (In years last birthday) 20 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
? | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
? | | | | | |
| 11. BIRTHPLACE (State or foreign country)
W. Va. | | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME
Earl S. Stinebaugh | | | | | 14. MOTHER'S MAIDEN NAME
Eileen Carbin | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
? | | 17. INFORMANT
Family Record | | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Multiple traumatic injuries
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | | | | | | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
NO | | | | | | | | | | |
| 20A. AUTOPSY? (Yes or No)
NO | | | | | | | | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
<input checked="" type="checkbox"/> CONTRIBUTING | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Tunnel | | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Harbor Tunnel Thruway & Exit 4B | | | | | 21D. TIME OF INJURY (APPROX.)
10 29 67 3:58 PM. | | | | | |
| 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR?
Subject was passenger in auto-fixed object collision | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE
Edward F. Wilson, M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) | | | | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
burial | | | | | 23B. DATE
11/2/67 | | 23C. NAME OF CEMETERY or CREMATORY
Bethel | | 23D. LOCATION (City, town, or county) (State)
Berkley Springs W. Va. | |
| 24A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | | | | 24B. NAME OF REGISTRAR
Robert E. Fairbank | | 24C. FUNERAL DIRECTOR
John R. Shuck | | ADDRESS
Edmond City | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|-------------------------------------|--|--|
| BIRTH NO. 67 10418 | | CERTIFICATE OF DEATH | | Registered No. 07 0410 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) BULLOCK, EDWARD | | 2. DATE AND HOUR OF DEATH
10/29/67 2.25 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)
LUTHERAN HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
3400 WALBROOK AVE. | | | |
| 5. SEX
M | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
1-6-1932 | 9. AGE (In years last birthday)
35 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machine Operator | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State, or foreign country)
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Edward Bullock Sr. | | 14. MOTHER'S MAIDEN NAME
Thelma Richardson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service)
Yes Korea | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Zelda Bullock - 3400 Walbrook Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CEREBRAL HEMORRHAGE | | 19. CAUSE OF DEATH
(A) DUE TO
HCVD
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
HOURS
YEARS | |
| 20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/29/67 to 10/29/67 that (I) (we) last saw the deceased alive on 10/29/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
F. Queral | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/29/67 | |
| 23C. PHYSICIAN'S NAME (Type)
F. QUERAL | | 23D. ADDRESS
LUTHERAN HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/2/67 | | 24C. NAME OF CEMETERY or CREMATORY
City Point | |
| 24D. LOCATION (City, town, or county) (State)
Hopewell Virginia | | 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. [unclear] | | 25C. FUNERAL DIRECTOR ADDRESS
Purnell B. Oden - Balto. Md. | | | |

10/23/57

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24-10-10

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HOUSING

CENTRAL MEMORANDUM

YEARS

HEAD

10/24

10/24/57

10/24

-

-

10/24

X

LUTHERAN HOSPITAL

F. GUNDEL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|--|---|--|
| 67 10419 | | BALTIMORE CITY HEALTH DEPARTMENT | | 67 10419 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
<i>OSCAR Phillips</i> | | 2. DATE AND HOUR OF DEATH
<i>10/29/67 11:50 P M.</i> | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>9-09</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Johns Hopkins Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>1303 - Harford Rd, Baltimore #2, Md</i> | | | |
| 5. SEX
<i>Male</i> | | 6. RACE
<i>Negro</i> | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Sep.</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Labourer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
<i>12/25/13</i> | |
| 13. FATHER'S NAME
<i>Isaac Phillips</i> | | 14. MOTHER'S MAIDEN NAME
<i>Annie Holloway</i> | | 9. AGE (In years last birthday)
<i>53</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>262-242587</i> | | 17. INFORMANT
<i>Jessie Phillips - 1303 Harford Ave</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>433.11</i> | | CAUSE OF DEATH
<i>? Cardiac arrhythmia</i> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO
<i>ASCD</i> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (B) DUE TO
<i>ASCD</i> | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from <i>9/4</i> 19 <i>67</i> to <i>10/29</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>10/27</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Henry R. Black</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>10/30/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>HENRY R. BLACK</i> | | 23D. ADDRESS
<i>Johns Hopkins</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11-4-67</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Mt Auburn</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Md</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>NOV 1 1967</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Furnell B. Oden - Balto. Md.</i> | | | |

511

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|----------------------|--|-----------------------------------|--|--|--|--|
| BIRTH NO. B-625 | | 67 10420 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10420 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Burgoyne Edgar L. | | | | 6-35 PM 10-26-1967 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital
Baltimore Md. | | | | A. STATE Baltimore | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
6-01 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
439 N Linwood Ave | | | |
| 5. SEX Male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
5-8-12 | 9. AGE (In years last birthday)
55 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Supervisor of Stores | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Burgoyne | | | | 14. MOTHER'S MAIDEN NAME
Mary Beever | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
215-07-8378 | | 17. INFORMANT
prev. adm. | | ADDRESS | |
| 18. 199.21
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ca of lung and brain, orthostatic pneumonia. | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
coronary anests | | | | (B) DUE TO | | | |
| | | | | (C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-21-1967 to 10-26-1967 , that (I) (we) lost saw the deceased alive on 10-26-19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Ogus makiu | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10-26-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10-30-67 | | 24C. NAME of CEMETERY or CREMATORY
Dulaney Valley Memorial | | 24D. LOCATION (City, town, or county) (State)
Timonium, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farber M.D. | | 25C. FUNERAL DIRECTOR
John C. Miller Inc-6415 Belair Rd. | | ADDRESS
-21206 | |

1875-76

1876-77

1877-78

1878-79

1879-80

1880-81

1881-82

1882-83

1883-84

1884-85

1885-86

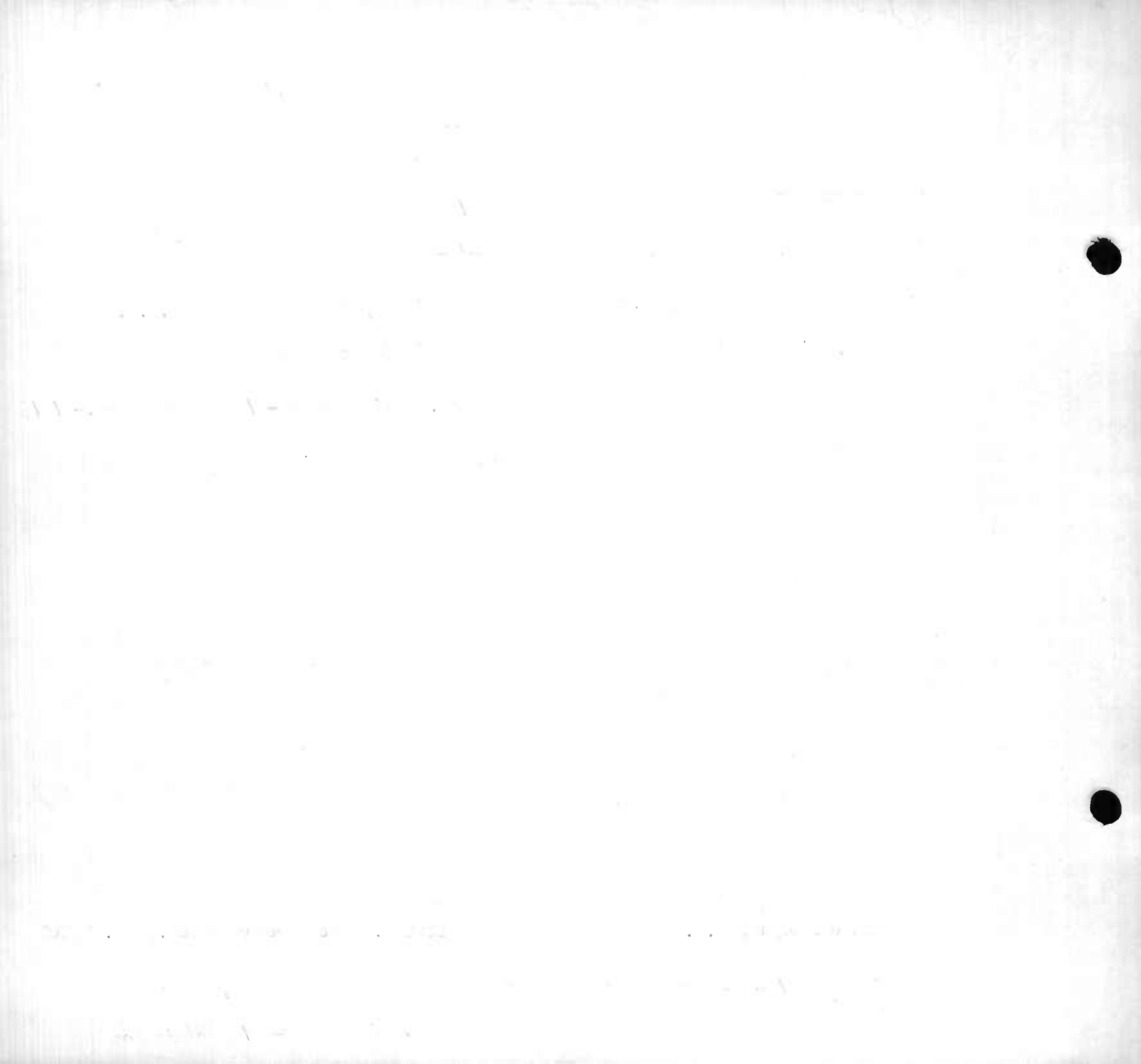
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|------------------------------------|--|--|
| BIRTH NO. <i>67 10421</i> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <i>67 10421</i> | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Andrew Winter</i> | | 2. DATE AND HOUR OF DEATH
<i>October 26, 1967</i> <i>5A.</i> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
<i>Gould Convalescent Home</i>
(If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>J-05</i>
D. STREET ADDRESS (If rural, give location) <i>1658 Darley Avenue</i> | | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH
<i>8-10-94</i> | 9. AGE (In years last birthday)
<i>73</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Time Keeper</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Emerson</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>John M. Winter</i> | | 14. MOTHER'S MAIDEN NAME
<i>Minnie Schaefer</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Yes</i> <i>WWI</i> | | 16. SOCIAL SECURITY NO.
<i>213-04-6911</i> | | 17. INFORMANT
<i>Mrs. Marie Kramer - 1658 Darley Ave. - 21213</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO <i>Carcinoma of the Rectum</i>
<i>with generalized metastases</i>
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
<i>not definite</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>9/22/67</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Carcinoma</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21C. HOW DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4-6-65</i> 19 to <i>10-26-</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>10-7-</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Samuel Legum</i> M.D. | | | | 23B. DATE SIGNED
<i>10-27-67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Samuel Legum, M.D.</i> | | 23D. ADDRESS
M.D. <i>1261 E. North Avenue Balto., Md. 21202</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>10-30-67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Baltimore National Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>NOV 1 1967</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR
<i>John C. Miller Inc-6415 Belair Road</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|------------|--|--------------------------------|---|--|--|--|
| BIRTH NO. 67-23403 | | 67 10422 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10422 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Baby Girl Perry | | | |
| 2. DATE AND HOUR OF DEATH 10-28-67 12:05 P.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy | | (If not in hospital or institution, give street address or location) | | A. STATE BALTIMORE MD | | B. COUNTY Baltimore Co. | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE MD | | D. STREET ADDRESS (If rural, give location) | | 5814 C. ANSTOCK AVE | |
| 5. SEX F. | 6. RACE W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE | 8. DATE OF BIRTH Oct. 28, 1967 | 9. AGE (In years last birthday) 1 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Eugene Perry | | | | 14. MOTHER'S MAIDEN NAME GLORIA STRANOVSKY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS EUGENE PERRY 5814 C. ANSTOCK AVE | | | |
| 18. 774X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH (A) Immaturity (B) Cardiopulmonary failure (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 H | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct. 28 19 67 to Oct. 28 19 67, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Sang Kyun Shin M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Oct. 28, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) SANG KYUN SHIN M.D. | | | | 23D. ADDRESS Mercy Hosp., Inc. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 11/1/67 | | 24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY | | 24D. LOCATION (City, town, or county) (State) Dundak MD | |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Fisher, MA | | 25C. FUNERAL DIRECTOR JOHN M. NEBERG | | ADDRESS 4015 CHESTER | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|--------------|---|--|---|---|
| L-520
BIRTH NO. 67 10423 | | 67 10423 | | 67 10423 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | |
| Marguerite P. Long | | | | 11-1-67 2:5 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1109 Poplar Hill Rd. | | | | A. STATE
Md. | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location)
1109 Poplar Hill Rd. | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
1-17-1891 | 9. AGE (In years last birthday)
76 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 11. BIRTHPLACE (State or foreign country)
Portsmouth, Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Judson B. Pendelton | | | 14. MOTHER'S MAIDEN NAME
Winifred Wilson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
-- | 17. INFORMANT
Mrs. G. E. Kostritsky | | ADDRESS
Above |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) Carcinoma of testis (origin undetermined)
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
6 months |
| | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
May 1967 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
as above | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 10 1967 to Nov 1 1967, that (I) last saw the deceased alive on Oct 20 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Alan Bernstein | | | | 23B. DATE SIGNED
11/1/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Alan Bernstein | | | 23D. ADDRESS
819 Park Avenue - Baltimore 1, Maryland | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-4-67 | | 24C. NAME OF CEMETERY or CREMATORY
Oak Grove | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Portsmouth Va. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
P. D. G. J. D. | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co., 4905 York Rd. Balto., Md. | |

(or. for a registration)
(BACI Nov 2012)

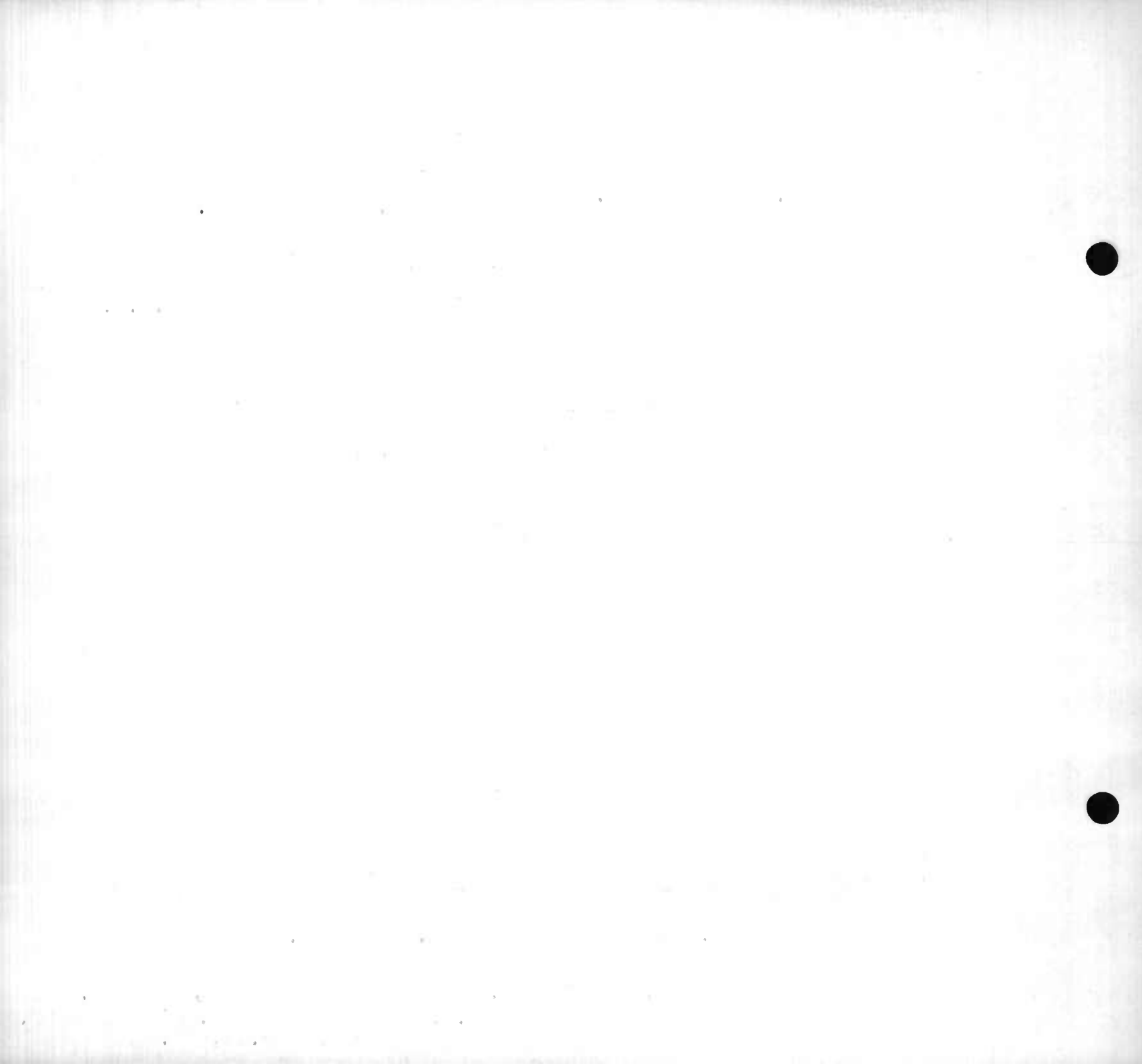
Nov 1967 on road

W. on B. in
Oct 2012
Nov 1967

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--------------|---|-------------------------------|--|--------------------------------|--|--|
| BIRTH NO. K-413 | | 67 10424 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10424 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | | |
| Stefan de Klepinski | | | | 2. DATE AND HOUR OF DEATH
October 31, 1967 3 ³⁰ P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | Maryland | | | |
| 5207 St. George's Ave. | | 5207 St. George's Ave. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | 5207 St. George's Ave. | | 27-10 | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
7/25/1876 | 9. AGE (In years lost birthday)
91 | 10. Under 1 Yr.
Months Days | 11. Under 24 Hrs.
Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
Farming | | 11. BIRTHPLACE (State or foreign country)
Poland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Jan de Klepinski | | | | 14. MOTHER'S MAIDEN NAME
Julia Krassiborska | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
820-54-8405 | | 17. INFORMANT
Miss Julia Klepinski | | ADDRESS
(Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, apoplexy, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) <i>Congestive Heart Disease</i>
DUE TO
(B) <i>Senescent & Cerebral Arteriosclerosis</i>
DUE TO
(C) _____
INTERVAL BETWEEN ONSET AND DEATH | | | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>Oct 31</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 31</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Walter B. Buck</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
11/1/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Walter B. Buck | | | | 23D. ADDRESS
M.D. 18 E. Eager St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/2/67 | | 24C. NAME of CEMETERY or CREMATORY
St. John's Cem. | | 24D. LOCATION (City, town, or county) (State)
Ellicott City, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 1 1967 | | 25B. NAME OF REGISTRAR
<i>Robert E. Jenkins</i> | | 25C. FUNERAL DIRECTOR ADDRESS
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | |
|---|--|
| <p>5-362 67 10425 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No. 67 10425</p> | |
| <p>BIRTH NO. 5-362</p> | |
| <p>M.E. CASE NO. 1</p> | |
| <p>1. NAME OF DECEASED (Type or Print) STREAKER, CHARLES W.</p> | |
| <p>2. DATE AND HOUR OF DEATH 10/31/67 10 30 A.M.</p> | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> | |
| <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY</p> | |
| <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE</p> | |
| <p>D. STREET ADDRESS (If rural, give location)
821 DARTMOUTH ROAD</p> | |
| <p>5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED</p> | |
| <p>8. DATE OF BIRTH 6-23-09 9. AGE (In years last birthday) 58</p> | |
| <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN CHAUFFEUR</p> | |
| <p>11. BIRTHPLACE (State or foreign country) MARYLAND</p> | |
| <p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p> | |
| <p>13. FATHER'S NAME STREAKER, CHARLES</p> | |
| <p>14. MOTHER'S MAIDEN NAME WALKER, SARAH</p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service) UNKNOWN YES - W W II</p> | |
| <p>16. SOCIAL SECURITY NO. 220-074663</p> | |
| <p>17. INFORMANT P. D. JONES ADDRESS UNION MEMORIAL HOP</p> | |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CIRCULATORY COLLAPSE</p> | |
| <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> | |
| <p>ANTECEDENT CAUSES MYOCARDIAL INFARCTION</p> | |
| <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTEROSCLEROTIC CORONARY DISEASE</p> | |
| <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS, GANGRENE</p> | |
| <p>19A. DATE OF OPERATION 10/30/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ARTERIAL OCCLUSION</p> | |
| <p>20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | |
| <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p> | |
| <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | |
| <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from 10/27 1967 to 10/31 1967, that (I) (we) last saw the deceased alive on 10/31 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | |
| <p>23A. SIGNATURE P. Dickson Jones M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p> | |
| <p>23B. DATE SIGNED 10/31/67</p> | |
| <p>23C. PHYSICIAN'S NAME (Type) P. DICKSON JONES M.D. 23D. ADDRESS UNION MEMORIAL HOSPITAL</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 11/2/67 24C. NAME OF CEMETERY or CREMATORY Good Shepherd 24D. LOCATION (City, town, or county) (State) Rogers Ave., Howard Co., Md.</p> | |
| <p>25A. DATE REC'D BY HEALTH DEPT. NOV 1 1967 25B. NAME OF REGISTRAR Robert E. Jenkins 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</p> | |

10/30/67 ASTERIAL OCCUSION

DIABETES MELLITUS (GANGRENE)

ASTEROSCLOTTIC CORONARY DISEASE
MYOCARDIAL INFARCTION
CIRCULATORY COLLAPSE

UNKNOWN

STRECKER, CHARLES
WALKER, SARAH
UNKNOWN
UNKNOWN
W
MARRIED
6-23-09 28
MARYLAND
USA

UNION MEMORIAL HOSPITAL
851 DARTMOUTH ROAD
BALTIMORE

P. Dickson Jones

10/31/67

10/27/67

67

10/31/67

UNION MEMORIAL HOSPITAL

44-40-53

ME

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------|---|---------------------------|--|---|
| R-260 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10426 | |
| BIRTH NO. 67 10426 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Recker, Margaret Ann | | 2. DATE AND HOUR OF DEATH 10/30/67 11:55 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| 31 | | D. STREET ADDRESS (If not in hospital or institution)
4040 EASTERN AVENUE, BALTIMORE, MARYLAND
600 St. Dunstons Rd, 21224 | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 10-27-89 | 9. AGE (In years lost birthday) 78 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bookkeeper | | 10B. KIND OF BUSINESS OR INDUSTRY Wonder Clothes | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME CHARLES THOMPSON | | 14. MOTHER'S MAIDEN NAME ADDIE MALONE | | 12. CITIZEN OF USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-05-68 | | 17. INFORMANT ADDRESS RECORDS BCH-4940 EASTERN AVENUE 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Urinary tract Infection
(B) CVA
(C) | | INTERVAL BETWEEN ONSET AND DEATH
2 days
2 yrs | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED White A1 Work <input type="checkbox"/> Not White A1 Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/6/65 to 10/30/67 that (I) (we) last saw the deceased alive on 10/30/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE NEIL WILLIAMSON, M.D. | | 23B. DATE SIGNED 10/31/67 | | 23C. PHYSICIAN'S NAME (Type) NEIL WILLIAMSON | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 11/3/67 | | 24C. NAME OF CEMETERY or CREMATORY Cedar Hill | |
| 25A. DATE REG'D BY HEALTH DEPT. NOV 1 1967 | | 25B. NAME OF REGISTRAR R. E. Jenkins | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | |

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11/22/79

11/22/79

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------------|--|---|--|--|
| BIRTH NO. 67 10427 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10427 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Gustav Adolf Wallander | | 2. DATE AND HOUR OF DEATH
October 25, 1967 7:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
40 St. Agnes Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Rhode Island
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Cranston
D. STREET ADDRESS (If rural, give location) 87 Colonial Avenue V-36 | | | |
| 5. SEX
Male | 6. RACE
Caucasian | 7. MARRIED, NEVER MARRIED
Married | 8. DATE OF BIRTH
July 8, 1890 | 9. AGE (In years lost birthday)
77 years | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painting Contractor | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Sweden | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Carl Wallander | | | 14. MOTHER'S MAIDEN NAME
Mathilda Fergerson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
039-12-7674 | | 17. INFORMANT ADDRESS
Juhlin-Pearson F. H. Providence, R. I. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Arterio Scl. Cardiovascular Disease
DUE TO
Generalized Arterioscl | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Emphysema and Bronchial Asthma | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on October 25, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J. Kudirka M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
J. Kudirka | | | | 23D. ADDRESS
M.D. Simpsonville, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/28/67 | | 24C. NAME of CEMETERY or CREMATORY
All Saints Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Warwick, R. I. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 2 1967 | | 25B. NAME OF REGISTRAR
G. E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks, Inc., 1217 St. Paul St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10428 | |
| BIRTH NO. 67 10428 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Long KAY DOVE | | 10/30/67 3:10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
JOHNS HOPKINS HOSPITAL.
N. BROADWAY.
BALTIMORE, MARYLAND. | | A. STATE
MARYLAND | |
| | | B. COUNTY | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
CROWNSVILLE | |
| | | D. STREET ADDRESS (If rural, give location)
1076 PLUM DRIVE. | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
NEVER MARRIED | 8. DATE OF BIRTH |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
STUDENT | | 10B. KIND OF BUSINESS OR INDUSTRY
— | 9. AGE (In years last birthday)
7 yrs. |
| 13. FATHER'S NAME
FLOYD W. DOVE | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 16. SOCIAL SECURITY NO.
NONE | | 14. MOTHER'S MAIDEN NAME
TESTER. NAOMI. | |
| 17. INFORMANT
Hospital Records | | ADDRESS | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) REYE'S SYNDROME
DUE TO

(B) DUE TO

(C) DUE TO | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | |
| 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
— | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)
— | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
— | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/24/1967 to 10/30/1967, that (I) (we) lost saw the deceased alive on 10/30/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
W. E. Bucknall | | 23B. DATE SIGNED
10/30/67 | |
| 23C. PHYSICIAN'S NAME (Type)
W. E. BUCKNALL | | 23D. ADDRESS
Box 33, JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/2/67 | |
| 24C. NAME OF CEMETERY or CREMATORY
Church of God Cemetery | | 24D. LOCATION (City, town, or county) (State)
Gambrells Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairburn | |
| 25C. FUNERAL DIRECTOR
Dorothy E. Haring | | ADDRESS
Hopping Road - Annapolis, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 50-34-66 | | H-163 | | 67 10429 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10429 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Mrs. Joseph H. Green</i> | | 2. DATE AND HOUR OF DEATH
<i>11/1/67</i> <i>12</i> <i>1</i> <i>A</i> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND - ANNE ARUNDEL Co.
B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
GLEN BURNIE - <i>52-00</i> | | D. STREET ADDRESS (If rural, give location)
1625 BEDFORD ROAD - 21061 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND | | 5. SEX
FEMALE | | 6. RACE
WHITE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
7-5-33 | |
| 9. AGE (In years last birthday)
34 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Housewife</i> | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
GREEN SCOTT | | 14. MOTHER'S MAIDEN NAME
ADELINE PAGE | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No.</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
RECORDS-BCH-4940 EASTERN AVENUE-BALTIMORE, MD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
204-31 | | CAUSE OF DEATH
(A) <i>A. K. Le-Remie 2nd Sepsis</i>
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | | 19. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) DUE TO | | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (if this hospital) attended the deceased from <i>10/17</i> 19 <i>67</i> to <i>11/1</i> 19 <i>67</i> , that (we) last saw the deceased alive on <i>11/1</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
<i>Murray A. Katz</i> | | 23B. DATE SIGNED
<i>11/1/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
DR. MURRAY A. KATZ | | 23D. ADDRESS
BCH-4940 EASTERN AVENUE, BALTIMORE, MD. | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/4/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Pace Cem Rosehill, Va | |
| 24D. LOCATION
Rose hill, Va | | 25A. DATE REC'D BY HEALTH DEPT.
NOV 2 1967 | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR
<i>Mc Gully F. H. 237 Potomac Ave</i> | | ADDRESS
<i>21225</i> | |

228

1
B-652
S-452

67 10430 BALTIMORE CITY HEALTH DEPARTMENT

67 10430

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ELEANOR

BURNS

Selenski

2. DATE AND HOUR PRONOUNCED DEAD

October 30, 1967

10:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

884 W. Lombard St.

18-03

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Unknown

8. DATE OF BIRTH

11/29/1910

9. AGE (In years last birthday)

56

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Packer

10B. KIND OF BUSINESS OR INDUSTRY

Lamp Bulb Co.

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Selenski

14. MOTHER'S MAIDEN NAME

Agnes Vaselanskas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

?

17. INFORMANT

Dr. Everett Burns

ADDRESS

Above

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/31/67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

11/2/67

23C. NAME of CEMETERY or CREMATORY

Eden Haven Cem.

23D. LOCATION (City, town, or county)

Pitohie Hwy

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 2 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

John J. Cowan & Son, Inc.

ADDRESS

981 St. Hollins

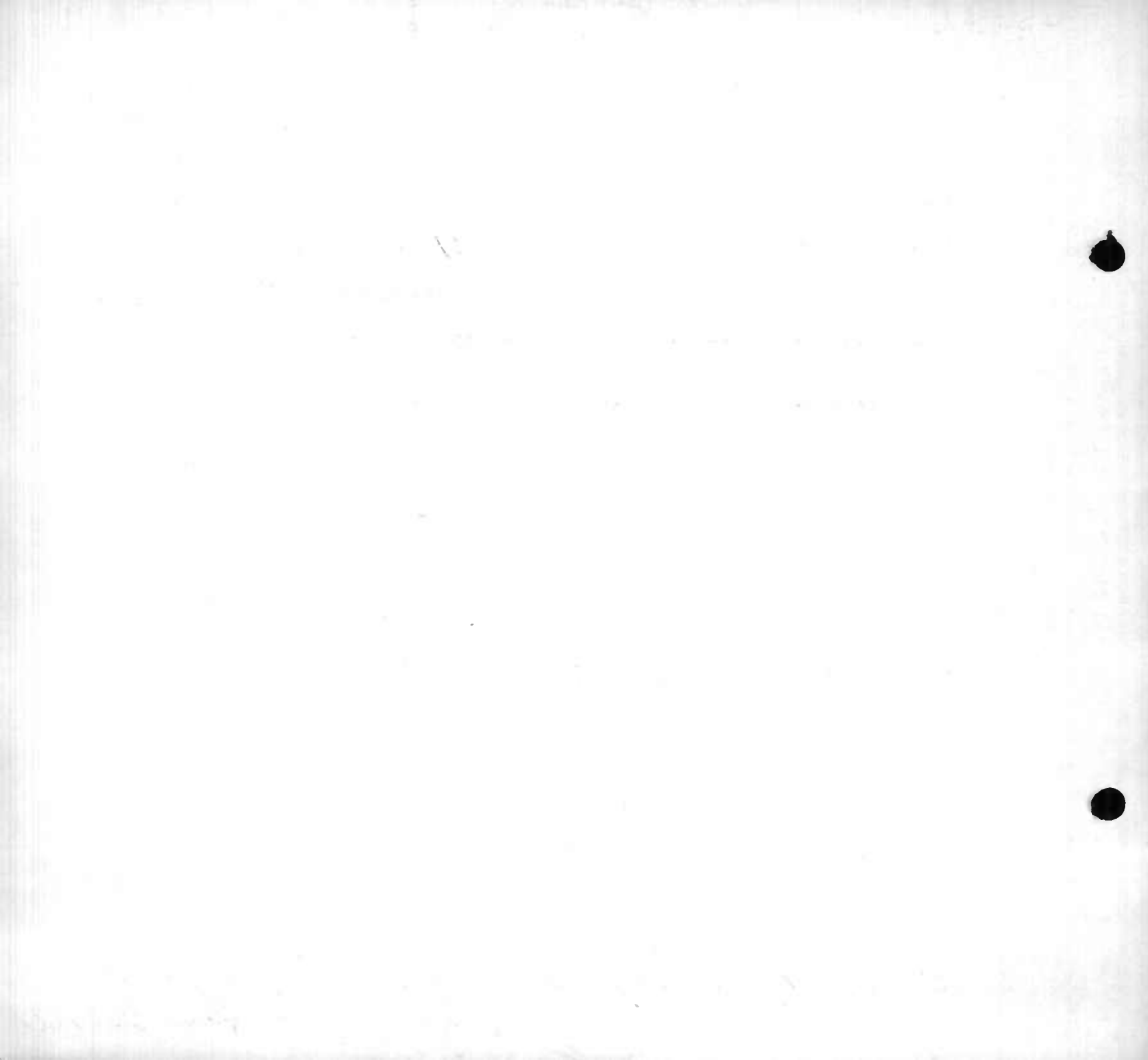
23, Md. ✓

2154 1978

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|------------------------|--|---------------------------------------|--|---|
| 67 10431 | | 67 10431 | | 67 10431 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | THOMAS R. FOARD JR. | | OCT. 31, 1967 8 ⁰⁰ AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | MARYLAND | | HARFORD CO. | |
| 48 MARYLAND GEN. HOSP. | | C. CITY OR TOWN | | (If outside city limits, write RURAL and give township) | |
| BALTO, Md. 827 LINDEN AVE. | | HAVRE DE GRACE | | 62-24 | |
| D. STREET ADDRESS (If rural, give location) | | 217 S. WASHINGTON ST. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| MALE | W | MARRIED | 12/22/16 | 50 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| SUP. | | U.S. GOV. | | MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| THOMAS R. FOARD | | AILEEN JOHNSON | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| X WW2 | | UMB. | | JULIA FURSYTHE HO 71113 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | 30 MIN. | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | BILAT. FEMORAL EMBOLECTOMY | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| OCT. 30, 1967 | | EMBOLISM FEM ART. BILATERAL | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from OCT. 30 1967 to OCT. 31 1967, that (I) (we) last saw the deceased alive on OCT. 31/1967 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| K. G. DRITSAS | | | | OCT. 31, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | M.D. 111 W. MONUMENT ST. BALTO, Md 21201 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) | (State) | |
| Burial | 11/3/67 | Harford Mem. Park | Albany, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | ADDRESS | | |
| NOV 2 1967 | Robert E. Fairbank | Thompson's Rm. Harford Mem. Park | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10432

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)
GEORGE

J.

MC INTIRE

MC INTIRE

2. DATE AND HOUR PRONOUNCED DEAD

October 30, 1967

5:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
 FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
 HOSPITAL OR ADDRESS OR LOCATION)
 11-13-67
 Baltimore City Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

Balto Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2453 Fairway

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 20, 1914

9. AGE (In years
last birthday)

52 21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machine operator

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles E. McIntire

14. MOTHER'S MAIDEN NAME

Anna Mae Norris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-07-2232

17. INFORMANT

ADDRESS

Mrs. Eleanor C. McIntire 2453 Fairway

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, steel, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/31/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

11/2/67

23C. NAME of CEMETERY or CREMATORY

Lorraine Cemetery

23D. LOCATION

(City, town, or county)

(State)

Woodlawn, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

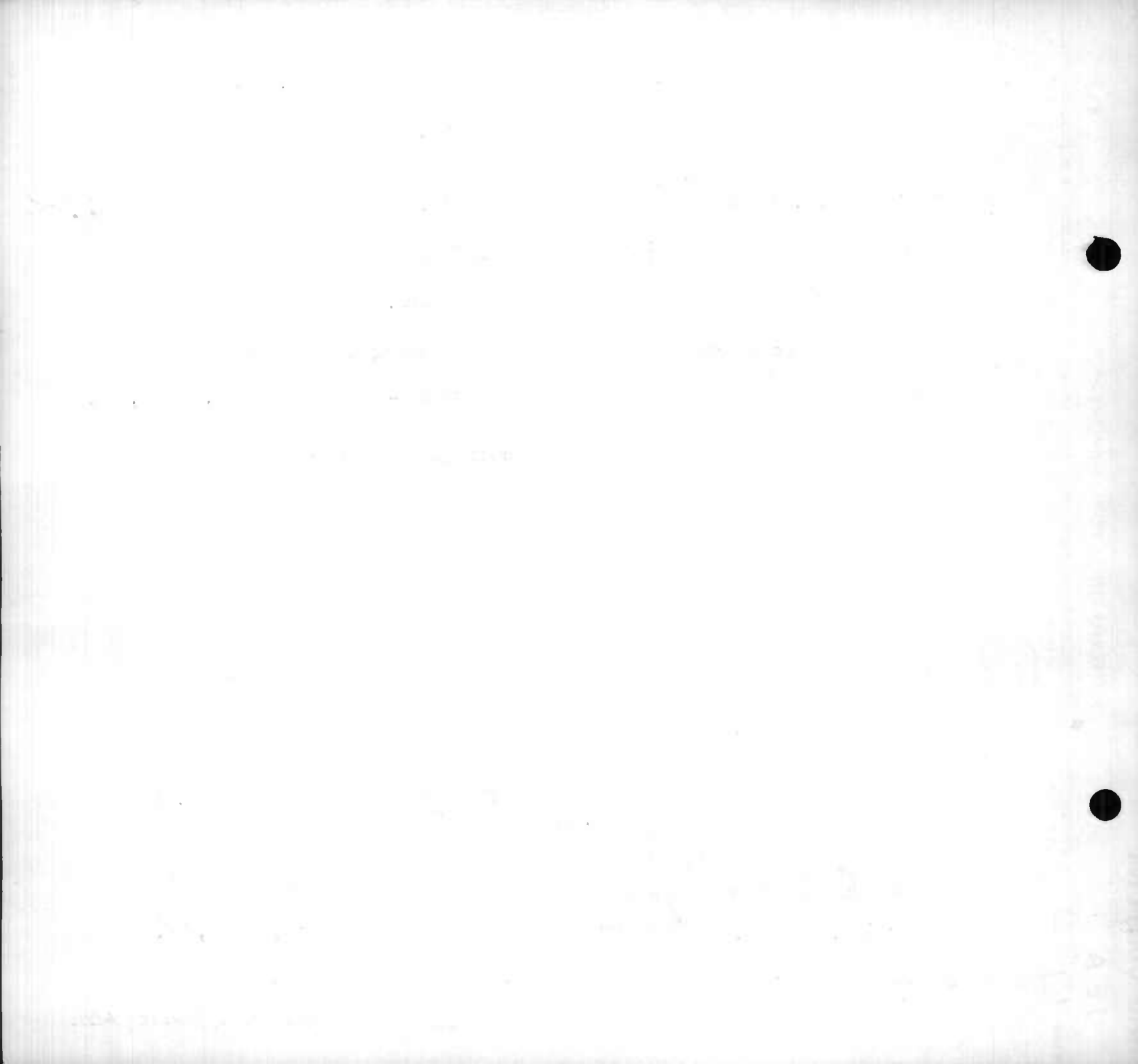
NOV 2 1967

Robert E. Fisher, M.D.

Ullrich Funeral Home Dundalk, Md.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | | | |
|---|--------------|--|------------------------------|--|----------------------------|--|-----------------------------|--|--|-------------------------------------|--|
| M.E. CASE NO. | | | | 67 10433 | | | | 67 10433 | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | Heidi Ann Weingartner | | | | 2. DATE AND HOUR OF DEATH
Oct. 31, 1967 1 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | Md. | | | | | | | |
| US Public Health Service Hospital
3100 Wyman Pk. Drive | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 12-02 | | | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
2905 Charles Street | | | | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
11/20/58 | 9. AGE (In years last birthday)
8 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
Conn. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Richard Weingartner | | | | 14. MOTHER'S MAIDEN NAME
Beverly Le Brecque | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Acute lymphocytic leukemia | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH
Months | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from July 13 19 67 to Oct. 31 19 67, that (1) (we) last saw the deceased alive on Oct. 31 1967 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Michael E. Pelczar | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
10/31/67 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Michael E. Pelczar, SA Surg (R) | | | | M.D. 23D. ADDRESS
US PHS Hospital, Balto, Md. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL/REMOVAL | | | | 24B. DATE
1 Nov. 67 | | | | 24C. NAME OF CEMETERY or CREMATORY
ST. BERNARD'S CEMETERY | | | |
| 24D. LOCATION (City, town, or county) (State)
HAZARDVILLE, CONN. | | | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 2 1967 | | | | 25B. NAME OF REGISTRAR
Robert E. Tashman | | | | 25C. FUNERAL DIRECTOR ADDRESS
ULLRICH FUNERAL HOME, BALTO., MD. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10434 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10434 | |
|---|---------------------|--|------------------------------------|--|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Leroy Cook | | | | 2. DATE AND HOUR OF DEATH
10/30/67 9⁰⁰ P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-05
D. STREET ADDRESS (If rural, give location) 4111 Overlea Ave | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Married | 8. DATE OF BIRTH
5/18/92 | 9. AGE (In years last birthday)
75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY
Insectasds | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Cook | | | | 14. MOTHER'S MAIDEN NAME
Ida ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes | | 16. SOCIAL SECURITY NO.
212-14-1034-A | | 17. INFORMANT
MRS. MAMMIE COOK | | ADDRESS
4111 OVERLEA | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Pneumonia
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Cerebral Vascular Accident | | | | INTERVAL BETWEEN ONSET AND DEATH
2 day
27 day | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2/1 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/31/67 to 10/30/67 , that (I) (we) last saw the deceased alive on 10/30/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
A. B. Einstein Jr.
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
10 | | | |
| 23C. PHYSICIAN'S NAME (Type)
A. B. Einstein, Jr. | | 23D. ADDRESS
Johns Hopkins Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
11/3/67 | | 24C. NAME OF CEMETERY or CREMATORY
MT. OLIVE | | 24D. LOCATION (City, town, or county) (State)
PANDALLS TOWN MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farber | | 25C. FUNERAL DIRECTOR ADDRESS
ULLRICH FUNERAL HOME 4210 BELMONT | | | |

A.B. FINESTERN, Jr.
 10/30/63
 10/30/63
 Johns Hopkins Hospital
 10

yes

Cerebral Vascular
 Accident
 2 days
 Pneumonia

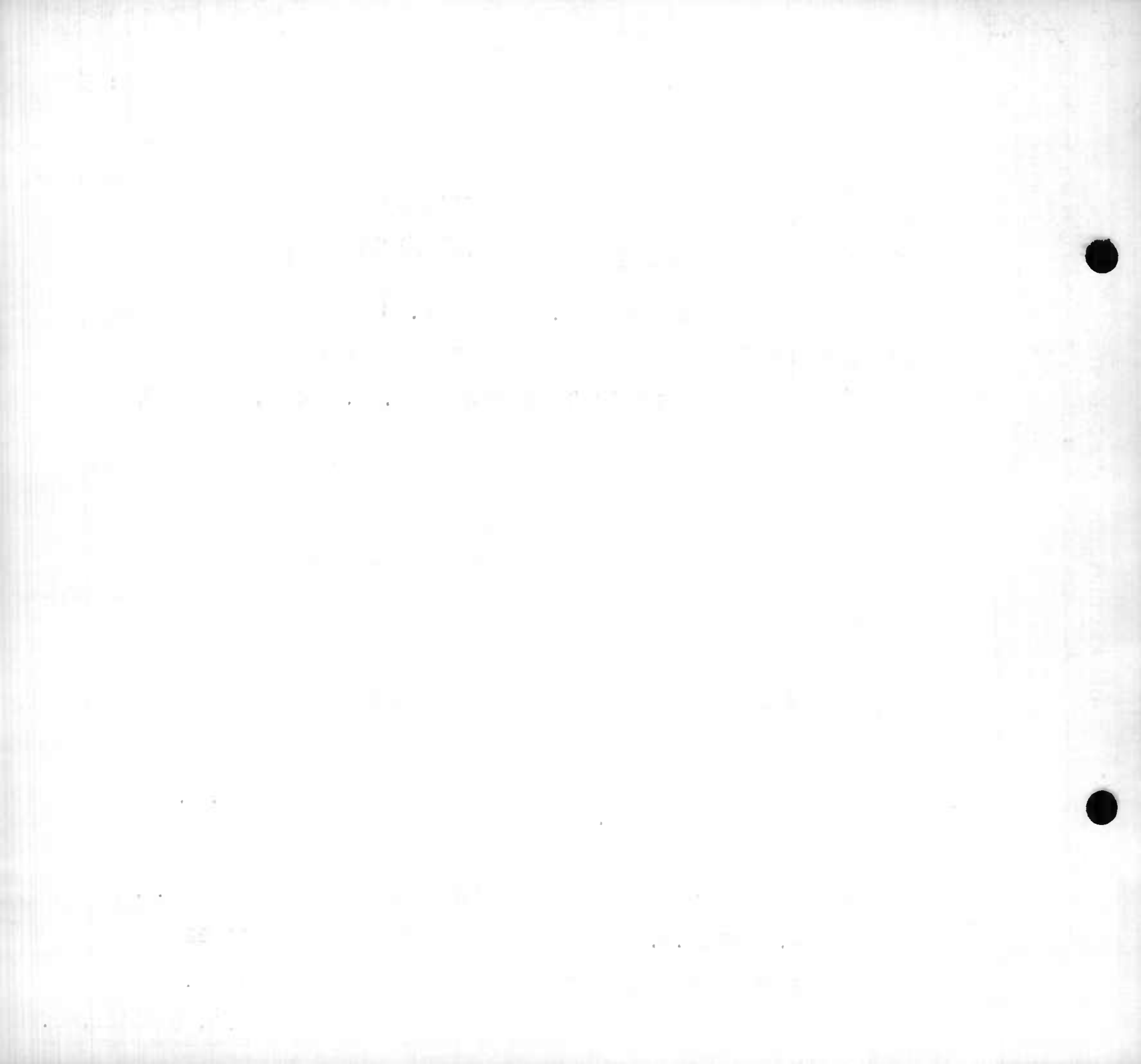
yes

John Cook
 Salesman
 W
 Married
 8/18/72
 411 Overton Ave
 Baltimore
 Maryland
 U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

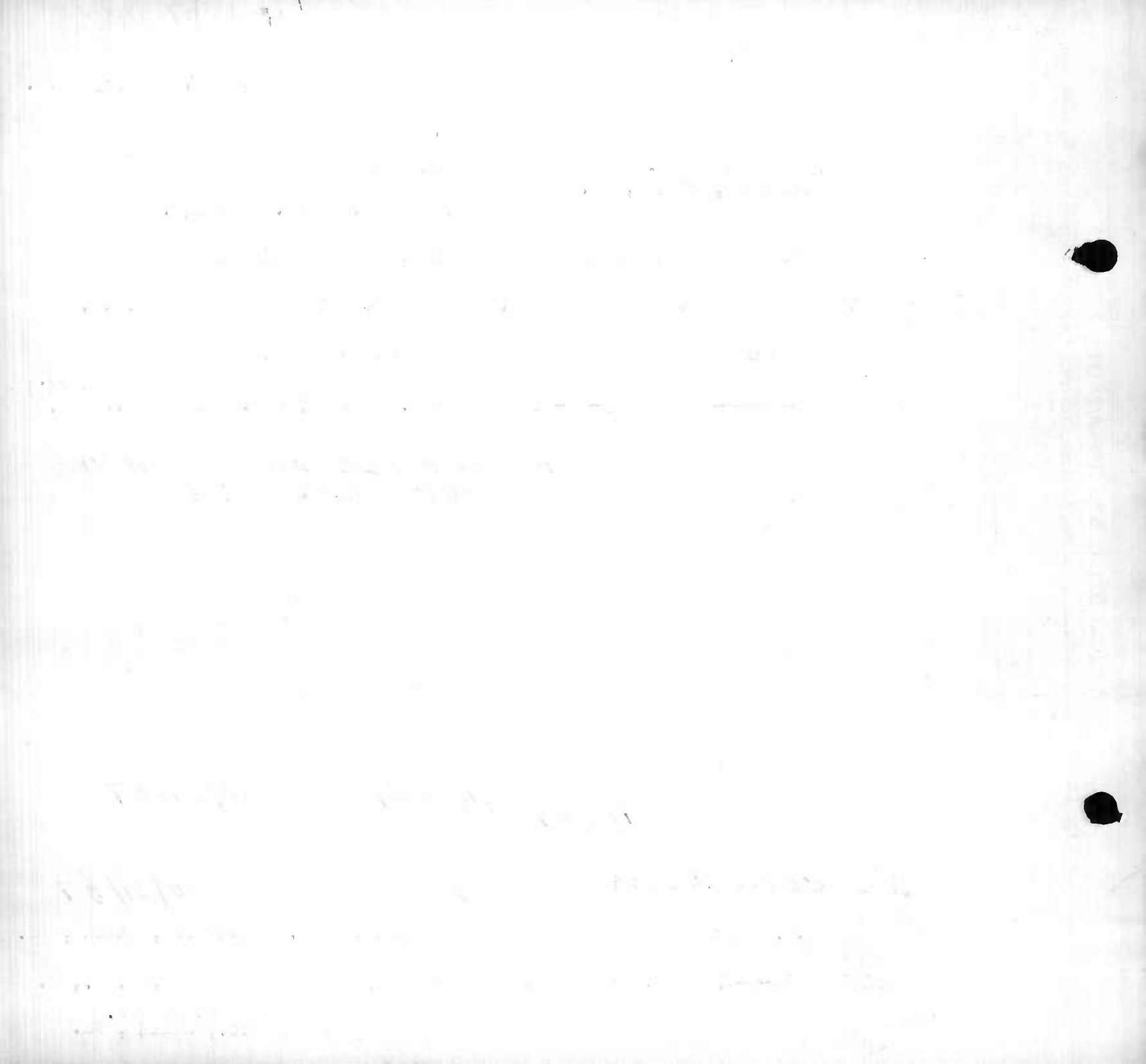
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 10435 | | 67 10435 | |
|--|--|--|--|--|--|--|--|
| BIRTH NO. | | | | 67 10435 | | Registered No. | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | KERMIT WALTER FOLEY | | 10/30/67 9:45 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 35 CHURCH HOME & HOSPITAL | | | | MARYLAND BALTIMORE 21222 Balt Co | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | DUNDALK 53-00 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 3125 SOLLERS POINT ROAD | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| MALE | | CAUCASIAN | | MARRIED | | 5/16/1919 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 9. AGE (In years last birthday) | |
| WAREHOUSEMAN | | STEEL MFR. | | PENNA. | | 48 | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME | | | |
| USA | | | | WALTER FOLEY | | | |
| 14. MOTHER'S MAIDEN NAME | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| ELSIE (?) | | | | YES WWII 174/01/1982 | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | |
| 174/01/1982 | | | | Margaret. L. Foley, AS IN 4 ABOVE | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | 19. CAUSE OF DEATH | | | |
| 3527.1 I | | | | coronary occlusion | | | |
| ANTECEDENT CAUSES | | | | 3 hours | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | emphysema | | | |
| II | | | | chronic duodenal ulcer | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| O | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1959 19 to 10.30.67 19 that (I) (we) last saw the deceased alive on 10.30 19 67 and that in (my) (aur) apnlan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did nat) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Eugene B. Nevy | | | | | | 11.1.67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| EUGENE B. NEVY, M.D. | | | | M.D. DUNDALK, MARYLAND 21222 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 11/2/1967 | | BALTIMORE NATIONAL | | BALTIMORE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. ADDRESS | | ADDRESS | |
| NOV 2 1967 | | Walter E. Fairley | | WALTER BROOKS BRADLEY, DUNDALK, MD. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 10436 | |
|--|-----------|--|--|--|---|
| BIRTH NO. | | | | 67 10436 | |
| M.E. CASE NO. | | | | Registered No. | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| ANTHONY HRICA | | | October 30, 1967 5:50 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | A. STATE
B. COUNTY | | |
| 00
6736 1/2 Boston Ave.
Baltimore, 21224, Md. | | | Md.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
26-36
D. STREET ADDRESS (If rural, give location)
6736 1/2 Boston Ave. # 21224. | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
lost birthday) | 10. If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| Male | White | Widowed | May 10, 1886 | 81 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired | | Bethlehem Steel Co. | | Czechoslovakia | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| George Hrica | | | U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| No | | | 213-07-2293A | | |
| 17. INFORMANT | | | ADDRESS | | |
| John J. Hrica | | | 702 S. Clinton St. Md.
21224; | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ARTERIO SCLEROTIC
CARDIOVASCULAR DISEASE | | | 10 YRS | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 2/10/1961 | | | 2/10/1961 | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (APPROX.) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/10/1961 to 10/27/67 and that (I) (we) last saw the deceased alive on 7/3/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| W.E. Baermann | | | 10/31/67 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| W.E. Baermann | | | 3401 Dundalk Ave. Baltimore, 21222, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 11-3-67 | Sacred Heart Cemetery | | 7401 German Hill Rd. Ba.Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME of REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| NOV 2 1967 | | Robert E. Fisher | | 6224 Eastern Ave. Balto., 21224, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | 67 10437 |
|---|---------|--|--------------------------|--|---|
| BIRTH NO. | | 67 10437 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Louis E. Kennedy | | October 29, 1967 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION

6300 Brook Avenue | | A. STATE
Maryland
B. COUNTY
Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| | | D. STREET ADDRESS (If rural, give location)
6300 Brook Avenue | | 27-05 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
lost birthday) | If Under 1 Yr.
Months Days
If Under 24 Hrs.
Hours Min. |
| Male | White | Married | April 17, 1901 | 67 | |
| 10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Chief Engineer | | Board of Education | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| William J. Kennedy | | | Sarah L. Harp | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Yes | | WWI & WWII | | Susan Frances Mary Kennedy-Same | |
| 18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN
ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | acute congestive heart failure | |
| ANTECEDENT CAUSES | | (B) DUE TO | | arterio sclerotic heart disease | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | 13 years | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | obesity | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1955 to 29 Oct 1967, that (I) (we) lost saw the deceased alive on 26 Oct 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| William F. Cox 3rd | | | | 30 Oct 67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| William F. Cox 3rd | | M.D. 1118 St. Paul St. Baltimore Md 21202 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 11-1-67 | | Baltimore National Cem. | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| NOV 2 1967 | | Robert E. Taylor, M.D. | | John G. Miller Inc-6415 Belair Rd.-21206 | |

Best vegetable food
and white potatoes 13 pms

Food

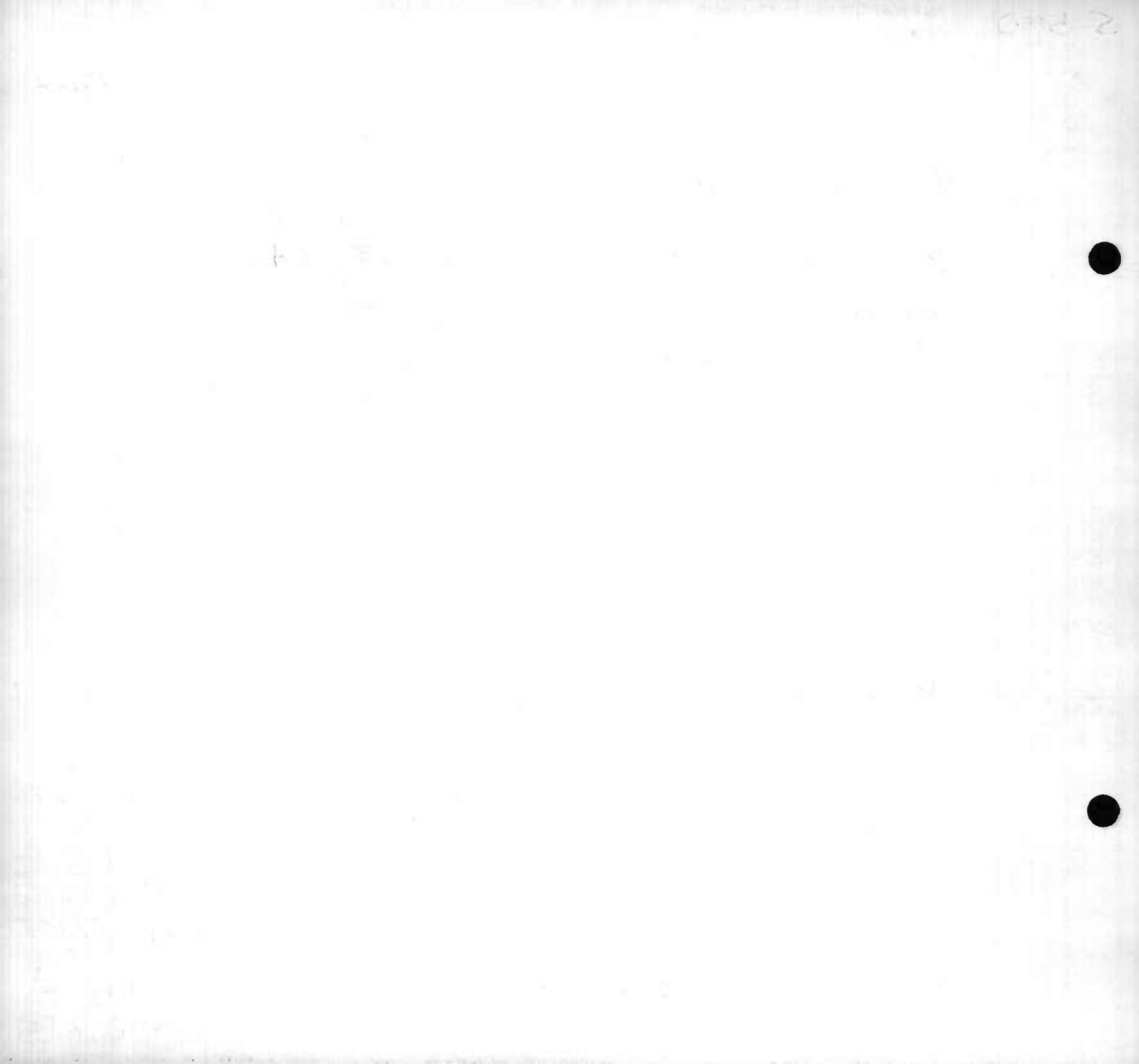
William R. Frost
Bureau of Census
1114 St. Paul St. B-19-14-41-2-2-2
20 Oct 41
20 Oct 41
20 Oct 41

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|-------------------------------------|--|---|
| 67 10438 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10438 | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Schuman, Isabel</i> | | 2. DATE AND HOUR OF DEATH
<i>10-31-67 12:10 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>North Charles General Hospital</i>
<i>49</i> | | A. STATE <i>Maryland</i>
B. COUNTY <i>21217</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>
D. STREET ADDRESS (If rural, give location) <i>903 Lake Drive</i>
<i>13-01</i> | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>4-9-1903</i> | 9. AGE (In years lost birthday)
<i>64 yrs</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>-</i> | | 11. BIRTHPLACE (State or foreign country)
<i>England</i> | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> |
| 13. FATHER'S NAME
<i>Charles Proser</i> | | 14. MOTHER'S MAIDEN NAME
<i>LENA</i> | | ADDRESS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | | 16. SOCIAL SECURITY NO.
<i>213-01-2309</i> | | 17. INFORMANT
<i>chart</i> | |
| 18. <i>199-2-1</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>Possible Bronchopneumonia</i>
DUE TO
(B) <i>CA of ovary & breast, left</i>
DUE TO
(C) <i>CVA with right hemiplegia</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-5-1967</i> to <i>10-31-1967</i> , that (I) (we) last saw the deceased alive on <i>10-31-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Aurora J. Lipolito</i> | | | | 23B. DATE SIGNED
<i>10/31/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Bix, Harold</i> | | 23D. ADDRESS
<i>1401 Reisterstown Road 21208</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11/2/67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Chel-Salem</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Maryland</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>NOV 2 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fisher</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>Sylvan Lewis & Son GAREISON, Md.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10439 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10439 | |
|--|-------------------------|---|--|--|--|---|--------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Elsie B. Holsey</i> | | | | 2. DATE AND HOUR OF DEATH
<i>10/31/67 10:15 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Bou Secours Hospital</i> | | (If not in hospital or institution, give street address or location) | | A. STATE
<i>Maryland</i> | | B. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore 20-04</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<i>2316 Frederick Ave Balto 23.</i> | | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>married</i> | | 8. DATE OF BIRTH
<i>1-1-90</i> | 9. AGE (In years lost birthday)
<i>77</i> | If Under 1 Yr.
Months Days | If Under 24 Hrs.
Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>at home</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Jacob Matthews</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Loretta ?</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>-</i> | | 17. INFORMANT
<i>Chart. Hosp.</i> | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <i>Arteriosclerosis Cardiovascular Disease and</i>
DUE TO
(B) <i>Congestive Heart Failure</i>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<i>years</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>-</i> | | 20A. AUTOPSY? (Yes or No)
<i>no</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/31</i> 19 <i>67</i> to <i>10/31</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>10/31</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>debravoy</i> | | | | | | 23B. DATE SIGNED
<i>10/31/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>CESAR A. BRAVO</i> | | | | 23D. ADDRESS
<i>Bou Secours Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11/4/67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>St. John's Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>St. John's, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>NOV 2 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fairbanks</i> | | 25C. FUNERAL DIRECTOR
<i>John J. Conway & Sons</i> | | ADDRESS
<i>901 Holling St. 23. Md.</i> | |

Mr. J. B. [unclear] [unclear]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|---------------------------------|---|---|
| BIRTH NO. 67 10440 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10440 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Andrew) <i>Anthony J. Siminski</i> | | 2. DATE AND HOUR OF DEATH <i>10-26-67 8³⁵ A.M.</i> | |
| 1. NAME OF DECEASED (Type or Print) | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| <i>37 Mercy Hospital</i> | | Md. | | City of Balt. | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | <i>Baltimore 1-03</i> | |
| | | D. STREET ADDRESS (If rural, give location) | | <i>7315 Luzerne Ave.</i> | |
| 5. SEX <i>m</i> | 6. RACE <i>w</i> | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (Specify) <i>married</i> | 8. DATE OF BIRTH <i>1-12-00</i> | 9. AGE (In years last birthday) <i>67</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CRANE OP.</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>AM. SMELTING</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i> | |
| 13. FATHER'S NAME <i>John Siminski</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Ann Wisniewski</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-01-9000</i> | | 17. INFORMANT <i>MRS. ANNAM. SIMINSKI</i> | |
| 18. <i>420.11+260X</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) <i>Cerebral Ischemia & functional decompensation</i> | | <i>1 day</i> | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | DUE TO | | | |
| ANTECEDENT CAUSES | | (B) <i>Coronary Artery</i> | | <i>"</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO | | | |
| | | (C) <i>Acute myocardial Infarction post Pulmonary Infarction</i> | | <i>"</i> | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Shigella soni, Cankers of Lung, Diabetes Mellitus years.</i> | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (this hospital) attended the deceased from <i>10-25 8:30 AM</i> to <i>10-26 19 67</i> and that (we) last saw the deceased alive on <i>10-26 19 67</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Philip W. Shoon</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>10-26-67</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>10-30-67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>ST. STANISLAUS CEMETERY BALTIMORE MD.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>NOV 2 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>RAYMOND L. KACZOROWSKI</i> | |
| | | | | ADDRESS <i>3525 FLEET ST.</i> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|-------------------------------------|--|---|
| BIRTH NO. 67 10441 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10441 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) ANTHONY W. DEBINSKI SR | | 2. DATE AND HOUR OF DEATH
10-25-67 1000 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 102
D. STREET ADDRESS (If rural, give location) 609 S. CURLEY ST. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 BALTIMORE City Hospital | | (If not in hospital or institution, give street address or location) | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
6-8-1904 | 9. AGE (In years last birthday)
63 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ENGINEER | | 10B. KIND OF BUSINESS OR INDUSTRY
W. VA. PAPER & PULP | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
JOSEPH DEBINSKI | | 14. MOTHER'S MAIDEN NAME
MARYANNA DEBINSKI | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MISS ANNA DEBINSKI | |
| 18. 381.04-52 | | CAUSE OF DEATH
Cirrhosis of the Liver | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pulmonary emphysema | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Nat White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 1967 to October 14, 1967 , that (I) (we) last saw the deceased alive on October 14, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | |
| 23A. SIGNATURE
Melito M. Torres | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10-27-67 | |
| 23C. PHYSICIAN'S NAME (Type)
MELITO M. TORRES, M.D. | | 23D. ADDRESS
441 S. ELLWOOD AVENUE BALTO. MD 21224 | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
10-28-1967 | | 24C. NAME OF CEMETERY or CREMATORY
ST. STANISLAUS | |
| 24D. LOCATION
BALTIMORE Md. | | 24E. DATE REC'D BY HEALTH DEPT.
NOV 2 1967 | | 24F. NAME OF REGISTRAR
R. D. & E. F. J. J. | |
| 24G. NAME OF REGISTRAR | | 24H. FUNERAL DIRECTOR
RAYMOND L. KACZOROWSKI | | 24I. ADDRESS
3525 FLEET ST. | |

The following is a list of the
 names of the persons who
 have been appointed to the
 various committees of the
 Board of Directors.

Committee of the Board

Following members

| | | |
|------------------|---|-------------------------|
| October 14, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 15, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 16, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 17, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 18, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 19, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 20, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 21, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 22, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 23, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 24, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 25, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 26, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 27, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 28, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 29, 1907 | ✓ | WILLIAM H. TORRES, M.D. |
| October 30, 1907 | ✓ | WILLIAM H. TORRES, M.D. |

WILLIAM H. TORRES, M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 10442</u> | |
|---|--------------------------------|--|---|--|--|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>66-10529</u> <u>67 10442</u> CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>LINDA YATES</u> | | | 2. DATE AND HOUR OF DEATH
<u>10-28-67</u> <u>1:05 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>THE JOHNS HOPKINS HOSPITAL</u>
<u>BALTIMORE, MD 21205</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY _____
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u>
D. STREET ADDRESS (If rural, give location)
<u>513 SOUTH ROSE STREET</u> | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>SINGLE</u> | 8. DATE OF BIRTH
<u>7-31-66</u> | 9. AGE (In years last birthday)
<u>1 YR</u> | If Under 1 Yr. Months: _____ Days: _____
If Under 24 Hrs. Hours: _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
_____ | | | 10B. KIND OF BUSINESS OR INDUSTRY
_____ | | 11. BIRTHPLACE (State or foreign country)
_____ |
| 12. CITIZEN OF WHAT COUNTRY?
_____ | | | 13. FATHER'S NAME
<u>TERRANCE YATES</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>LINDA DUNCAN</u> | | | 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
_____ | | |
| 16. SOCIAL SECURITY NO.
_____ | | | 17. INFORMANT
<u>MRS. LINDA YATES</u> | | |
| 18. ADDRESS
<u>513 S. ROSE ST.</u> | | | 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Metabolic derangement</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Sub acute hepatitis</u> | | |
| 20. INTERVAL BETWEEN ONSET AND DEATH
_____ | | | 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
_____ | | |
| 22A. DATE OF OPERATION
<u>2</u> | | 22B. CONDITION FOR WHICH OPERATION WAS PERFORMED
_____ | | 22C. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 22D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
_____ | | 23. MEDICAL CERTIFICATION
23A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>
23B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
23C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
23D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
23E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
23F. HOW DID INJURY OCCUR?
_____ | | | |
| 24. I certify that (I) (this hospital) attended the deceased from <u>October 27</u> 19 <u>67</u> to <u>October 28</u> 19 <u>67</u>, that (I) (we) last saw the deceased alive on <u>October 28</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 25A. SIGNATURE
<u>[Signature]</u> | | | | 25B. DATE SIGNED
<u>10-28-67</u> | |
| 25C. PHYSICIAN'S NAME (Type)
<u>William FRENCK</u> | | | | 25D. ADDRESS
<u>Johns Hopkins Hospital</u> | |
| 26A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 26B. DATE
<u>10/31/67</u> | | 26C. NAME OF CEMETERY OR CREMATORY
<u>HOLY ROSARY CEMETERY</u> | |
| 26D. LOCATION (City, town, or county) (State)
<u>BALTIMORE Co.</u> | | 27. DATE REC'D BY HEALTH DEPT.
<u>NOV 2 1967</u> | | | |
| 28. NAME OF REGISTRAR
<u>Robert E. Farber</u> | | 29. FUNERAL DIRECTOR
<u>RAYMOND L. KACZOROWSKI</u> | | | |
| 30. ADDRESS
<u>2525 FLEET ST.</u> | | _____ | | | |

Wabbe's description
of some species

Yes

October 28 1891
October 29 1891

John H. Brown

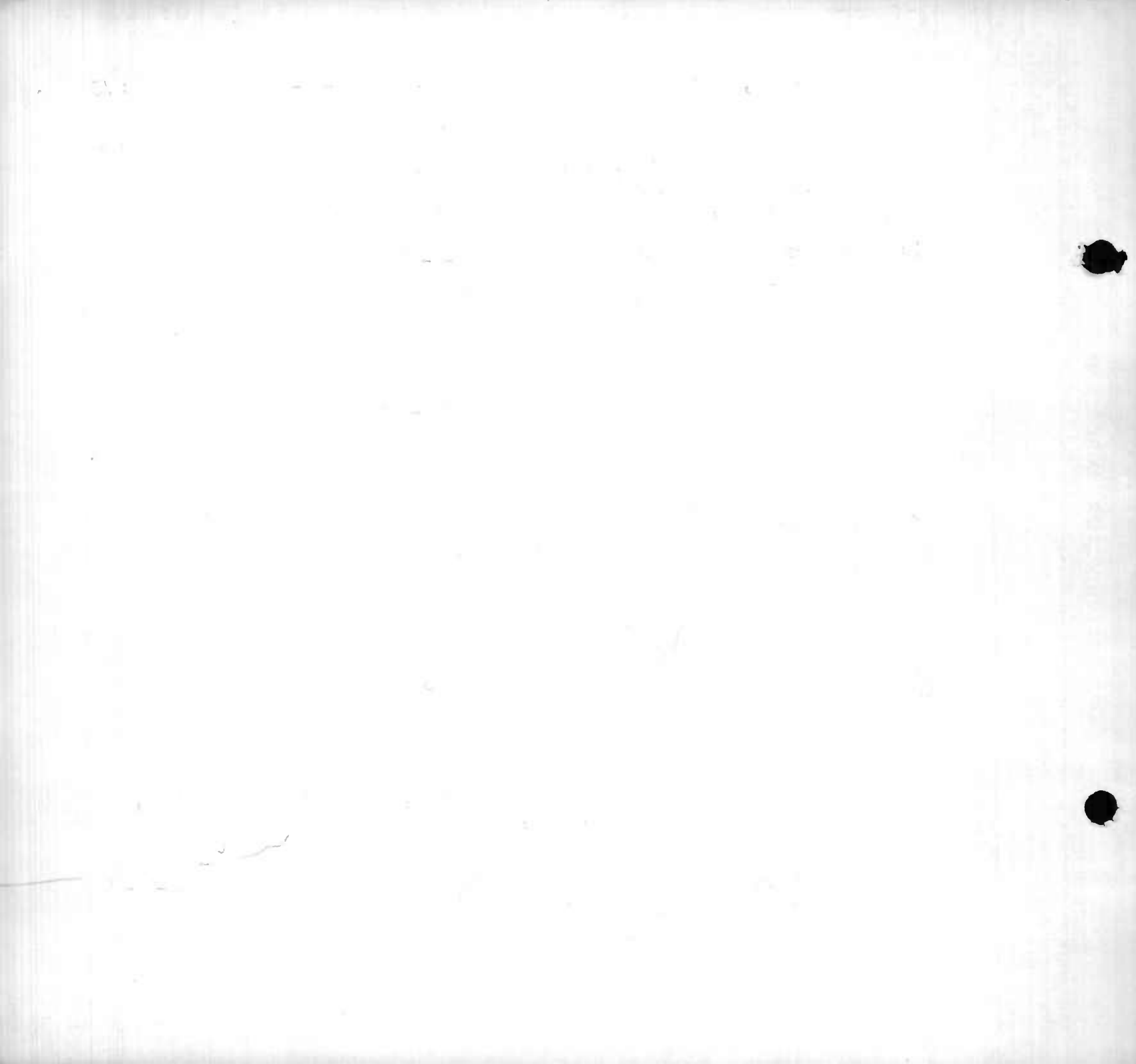
John H. Brown

John H. Brown
John H. Brown

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. | |
|---|--|---------------|--|--|--|--|--|--|--|---|--|
| BIRTH NO. 67 10443 | | | | | | | | | | 67 10443 | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Myers, David | | | | | | | | | | 2. DATE AND HOUR OF DEATH 10-30-67 5:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland | | | | | | | | | | A. STATE Maryland | |
| 39 | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) 2005 Ruxton Avenue | |
| 5. SEX Male | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 12-5-67 | | 9. AGE (In years last birthday) 82 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | | | 11. BIRTHPLACE (State or foreign country) Jamaica | | 12. CITIZEN OF WHAT COUNTRY? Jamaica | |
| 13. FATHER'S NAME Thomas Myers | | | | | | 14. MOTHER'S MAIDEN NAME Elizabeth | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Edith- Wife | | | | ADDRESS SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | CAUSE OF DEATH | |
| 331X I | | | | | | | | | | CEREBRAL HEMORRHAGE | |
| ANTECEDENT CAUSES | | | | | | | | | | GENERALIZED ARTERIOSCLEROSIS | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II | | | | | | | | | | ESSENTIAL HYPERTENSION | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? Yes or No No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from October 29, 19 67 to October 30, 19 67, that (I) (we) last saw the deceased alive on October 30, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE G. L. Banfield | | | | | | | | | | 23B. DATE SIGNED 10-30-67 | |
| 23C. PHYSICIAN'S NAME (Type) G. L. BANFIELD | | | | | | | | | | 23D. ADDRESS 722 N. Fulton Ave Balt. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE 11-2-67 | | 24C. NAME of CEMETERY or CREMATORY Antietam Cent | | | | 24D. LOCATION (City, town, or county) (State) Laurel Md | |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 2 1967 | | | | 25B. NAME OF REGISTRAR Robert E. Farber | | | | 25C. FUNERAL DIRECTOR Elroy Wilkerson | | | |
| | | | | | | | | | | ADDRESS Brambley Bee | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10444

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

October 31, 1967 7:25 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1207 Chatham Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1207 Chatham Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

August 6, 1916

9. AGE (In years
last birthday)

50?

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Williams

14. MOTHER'S MAIDEN NAME

Doris Auster

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

16. SOCIAL
SECURITY NO.

218-01-8349

17. INFORMANT

ADDRESS

Doris Hill 908 Rutland Ave

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) ~~X~~ ~~Arteriosclerotic~~Arteriosclerotic Cardiovascular
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) ~~X~~ ~~Due to~~(C) ~~X~~ ~~Due to~~

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 1, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

11-3-67

23C. NAME OF CEMETERY or CREMATORY

Baltimore Nat Cent

23D. LOCATION

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

NOV 2 1967

24B. NAME OF REGISTRAR

Robert E. F. Wilson

24C. FUNERAL DIRECTOR

Edward F. Wilson 1001 Bunting Ave

ADDRESS

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

W. A. R. 1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|---------|--|------------------|---|---|---|---------------------------------|
| BIRTH NO. B-650 | | 67 10445 | | BALTIMORE CITY HEALTH DEPARTMENT | | 67 10445 | |
| M.E. CASE NO. | | | | Registered No. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| James E. Brown | | | | 10/31/67 12 42 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | | Maryland | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 646 South Streeper Street 21224 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
lost birthday) | 10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF
WHAT COUNTRY? |
| Male | White | Married | 12-20-1881 | 85 | Machinist | Maryland | U.S.A. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| James | | | | Mary Ellen | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| No | | | | 215-01-4729 | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| Records: BCH-4940 Eastern Avenue | | | | 21224 | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | Hours | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | Myocardial Infarction | | | |
| ANTECEDENT CAUSES | | | | Years | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Generalized Arteriosclerosis | | | |
| II | | | | years | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Squamous cell Carcinoma, Skin of head & extension | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? | |
| 10-30-67 | | Squamous cell Carcinoma | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| No | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-17 1967 to 10-31 1967, that (I) (we) last saw the deceased alive on 10-30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | | | 23B. DATE SIGNED | |
| Thomas John Zirkle | | | | | | 10-31-1967 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Thomas John Zirkle | | | | 4940 Eastern Avenue, Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 11-3-67 | | Oaklawn Cemetery | | Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| NOV 2 1967 | | Robert E. Salyer | | B. Dabrowski | | 2818 E. Baltimore St. | |

1
G-650

67 10446 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10446

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

NORMAN

GUERIN

2. DATE AND HOUR PRONOUNCED DEAD

October 23, 1967

2:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hospt.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2613 N. Calvert Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
DIVORCED

8. DATE OF BIRTH

1/26/29

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

LOUISIANA

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

OLIVER GUERIN

14. MOTHER'S MAIDEN NAME

NELLIE HEBERT

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give wot or dates of service)16. SOCIAL SECURITY NO.
435-36-8388

17. INFORMANT

Mrs. Frank Curry

ADDRESS

1619 Center St. - Arabi, La.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

10/24/67

23A. BURIAL CREMATION,
REMOVAL (Specify)
BURIAL

23B. DATE

11/3/67

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

New Orleans, La.

24A. DATE REC'D BY HEALTH DEPT.

NOV 2 1967

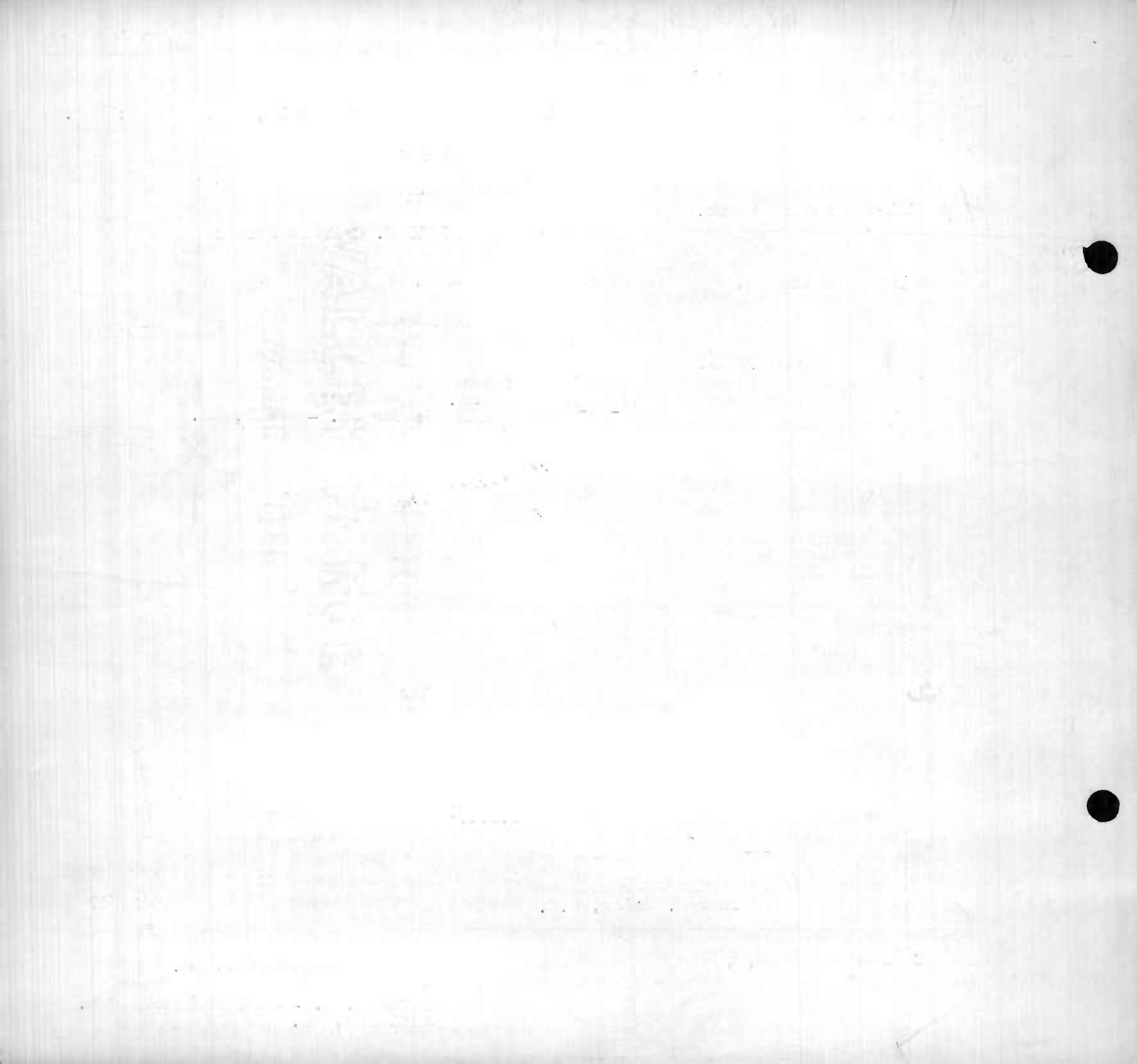
24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Witzke F. D. - 4101 Edmondson Ave.
Baltimore, Md.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-----------------------------|--|--|
| BIRTH NO.
67 10447 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No.
67 10447 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Emma M. Eyer (Mary E. - Marie E.) | | 2. DATE AND HOUR OF DEATH
Oct. 30, 1967 8:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
3157 Leeds St.
00 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
3157 Leeds Street | | | |
| 5. SEX
F | 6. RACE
Cauc. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
2/14/84 | 9. AGE (In years last birthday)
83 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Bowen | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Miss Mildred Bowen
3157 Leeds St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
422.1 I
Arteriosclerotic C.V.D. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
years | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1966 to Oct 30 1967, that (I) (we) last saw the deceased alive on Oct 30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
John C. Pound M.D. | | | | 23B. DATE SIGNED
10/31/67 | |
| 23C. PHYSICIAN'S NAME (Type)
John C. Pound | | 23D. ADDRESS
3325 Frederick Avenue M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
11/3/67 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fabe | | 25C. FUNERAL DIRECTOR
Witzke F.D. 4101 Edmondsob Ave. | |
| | | | | ADDRESS | |

10 9 2 4 1 2 3 4 5 6 7 8 9 10

10 9 8 7 6 5 4 3 2 1

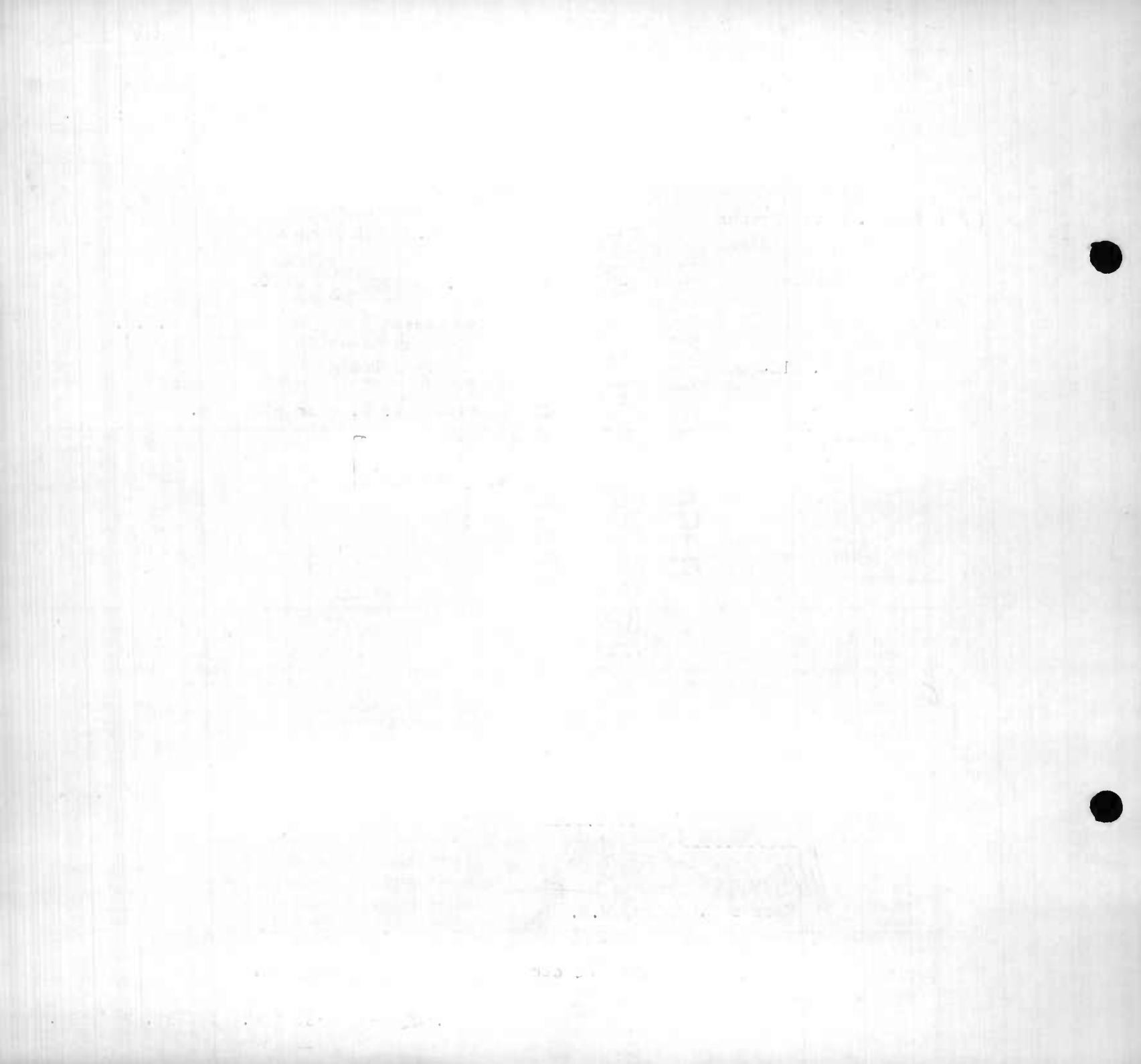
10 9 8 7 6 5 4 3 2 1

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
|--|--|--|--|
| MAURICE Clayton THOMPSON | | October 29, 1967 7:05 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE
Maryland | |
| 00 306 E. North Avenue | | B. COUNTY
Baltimore | |
| 5. SEX
Male | | 6. RACE
White | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Divorced | | 8. DATE OF BIRTH
Nov. 7, 1923 | |
| 9. AGE (In years last birthday)
43 5X | | 10. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Odd jobs | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Tennessee | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Frank H. Thompson | | 14. MOTHER'S MAIDEN NAME
Julia Johnson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
408-38-9118 | |
| 17. INFORMANT
Davidson F. H. Rose Hill, Va. | | ADDRESS | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Pulmonary Tuberculosis
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
1967 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) | |
| 21E. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK [] | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry [] Inspection [X] Autopsy [] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner [] | | | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER []
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [] | |
| DATE SIGNED
10/29/67 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
11/2/67 | |
| 23C. NAME OF CEMETERY or CREMATORY
Edds Cemetery | | 23D. LOCATION (City, town, or county) (State)
Ewing, Va. | |
| 24A. DATE REC'D BY HEALTH DEPT.
NOV 2 1967 | | 24B. NAME OF REGISTRAR
Robert E. Farley, M.D. | |
| 24C. FUNERAL DIRECTOR
Wm. Cook-Brooks, Inc. 1217 St. Paul St. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-------------------------|---|---|---|---|--|---|
| BIRTH NO. K-500 | | 67 10450 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10450 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) ANNE CAREY KENNEY | | | |
| 2. DATE AND HOUR OF DEATH
10-31-67 | | | | M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 3714 Hillsdale Rd | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| D. STREET ADDRESS (If rural, give location)
3714 Hillsdale Rd. | | | | 28-41 | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
AUG 2, 1885 | 9. AGE (In years last birthday)
82 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At Home | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Aloysius Carey | | | 14. MOTHER'S MAIDEN NAME
McGlannan | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Edward Kenney - 119 Hawthorne Ave #8 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
420.01
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Anterior Sclerotic Heart Disease | | | CAUSE OF DEATH
(A) DUE TO
Anterior Sclerotic Heart Disease
(B) DUE TO
-
(C) DUE TO
- | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs. | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Generalized Arterio Sclerosis | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept - 6 - 1967 to Oct. 31 - 1967 , that (I) was last saw the deceased alive on Oct. 30 - 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | | | |
| 23A. SIGNATURE
Earl L. Chambers | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
11/1/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Earl L. Chambers - | | | | 23D. ADDRESS
4108 Liberty Hts Balto. Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-3-67 | | 24C. NAME of CEMETERY or CREMATORY
Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State)
Balto., Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
Ellsworth Armacost - 4600 Liberty Hts | | ADDRESS | |



| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
|---|------------------|--|---------------------------------------|
| John Franklin Smith
FRANK J. SMITH | | October 29, 1967 2:22 p.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 2425 Harriet Ave. | | A. STATE
Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2425 Harriet Ave. | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Aug. 3, 1918 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY
Insurance | 9. AGE (In years last birthday)
49 |
| 13. FATHER'S NAME
John Henry Smith | | 11. BIRTHPLACE (State or foreign country)
West Virginia | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW1 | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14. SOCIAL SECURITY NO.
214-07-3528 | | 14. MOTHER'S MAIDEN NAME
Bessie Elizabeth Smith | |
| 17. INFORMANT
MRS. IRENE (CHESS) SMITH | | ADDRESS
817 STOLL STREET
BALTIMORE MD. | |
| 18. CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc., it means the disease, injury or complication which caused death.)
E 976 X I
Gunshot wound of the chest | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | |
| 21D. TIME OF INJURY (APPROX.)
10 29-30 67 ? | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
2425 Harriet Ave. | |
| 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Subject shot himself in the chest | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Edward F. Wilson, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
Nov. 2, 1967 | |
| 23C. NAME OF CEMETERY or CREMATORY
Baltimore Nat'l Cemetery | | 23D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT.
NOV 2 1967 | | 24B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 24C. FUNERAL DIRECTOR
H. Lee Silcox | | ADDRESS
404 Decatur St. Cumb. Md. | |

WILLIAM L. BRYAN

W. L. BRYAN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| BIRTH NO. 2600 | | 67 10452 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10452 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) NORMAN PERRY | | | |
| 2. DATE AND HOUR OF DEATH
10-31-67 4:00 A.M. | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
Lincoln Memorial Nursing Home | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location)
27 N. CAREY STREET | | | | 18-02 | | | |
| 5. SEX
MALE | | 6. RACE
NEGRO | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
10-7-1900 | |
| 9. AGE (In years last birthday)
67 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 11. BIRTHPLACE (State or foreign country)
Notaway County, Md. | | 12. CITIZEN OF WHAT COUNTRY?
UNKNOWN | |
| 13. FATHER'S NAME
UNKNOWN James Perry | | | | 14. MOTHER'S MAIDEN NAME
UNKNOWN Helen Williams | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKNOWN | | | | 16. SOCIAL SECURITY NO.
719-07-8841 | | 17. INFORMANT
Algie Perry | |
| 18. 332X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CEREBRAL THROMBOSIS | | | | CAUSE OF DEATH
(A) CEREBRAL THROMBOSIS
(B) ARTERIOSCLEROSIS
(C) PNEUMONIA | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-17-67 19 to 10-31-1967 , that (I) (we) last saw the deceased alive on 10-31-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
H. J. Sewarke | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/31/67 | |
| 23C. PHYSICIAN'S NAME (Type)
H. J. Sewarke | | | | 23D. ADDRESS
5514 KENNISON AVE BALT MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/3/67 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cem. | | 24D. LOCATION (City, town, or county) (State)
A.A. County Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
Frank E. Eickow | | ADDRESS
1229 N. Caroline St | |

3442

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

1428-75-017

1123795-220-93796

Wm. L. Garrison

BIRTH NO. 65-04723 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10453

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANTIONETTE CARLOS

2. DATE AND HOUR PRONOUNCED DEAD

October 26, 1967 1:40 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1126 Webb Ct.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

2½

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Bald. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Larry Carlos

14. MOTHER'S MAIDEN NAME

Lorraine Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; if yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lorraine Carlos 1126 Webb Court

18. E9369 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Undetermined

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Undetermined

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

10-26-67 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Undetermined

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 26, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

Oct. 29/67

23C. NAME of CEMETERY or CREMATORY

Mt. Airy Cem

23D. LOCATION (City, town, or county)

A.A. County Md

24A. DATE REC'D BY HEALTH DEPT.

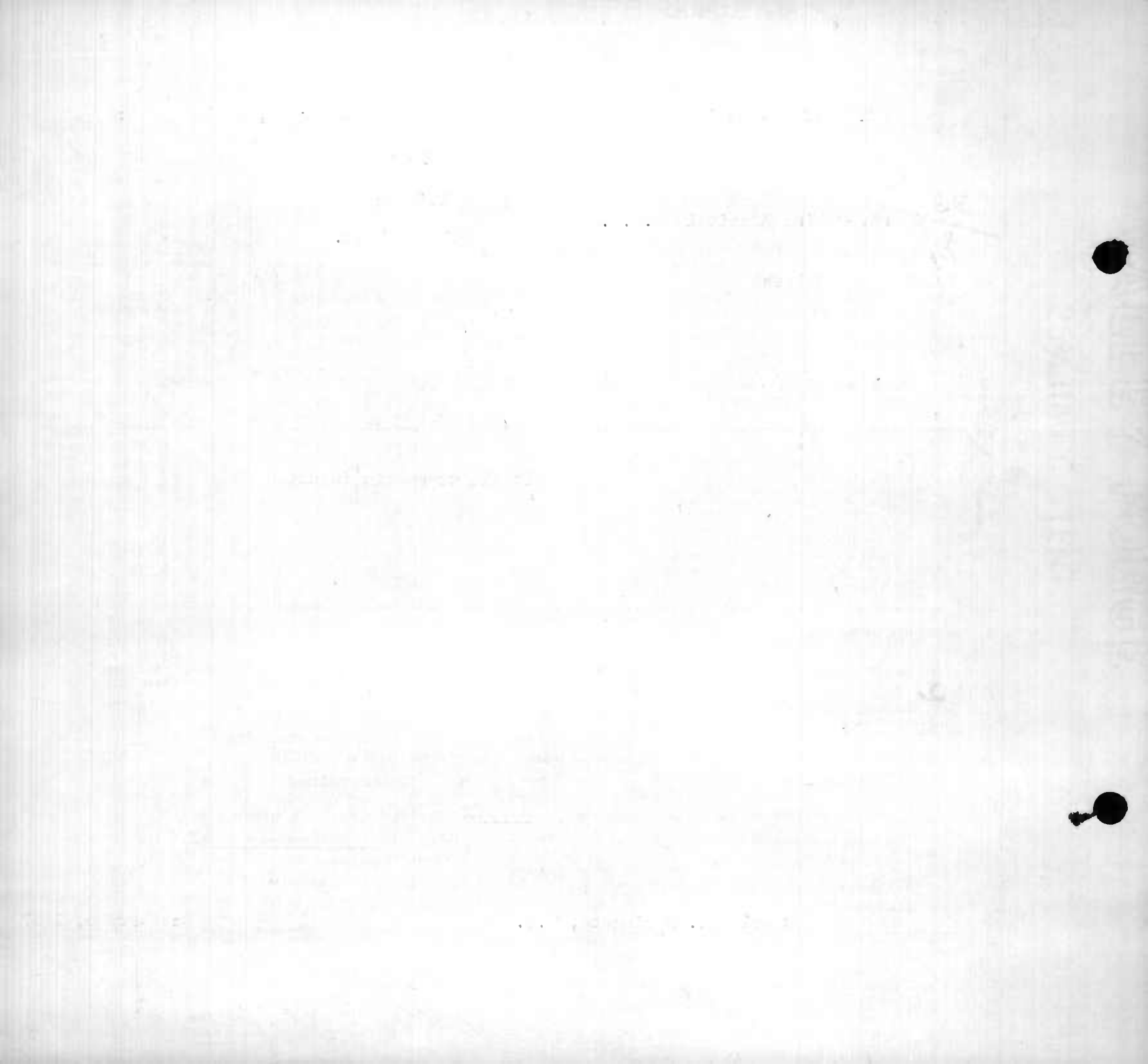
NOV 2 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

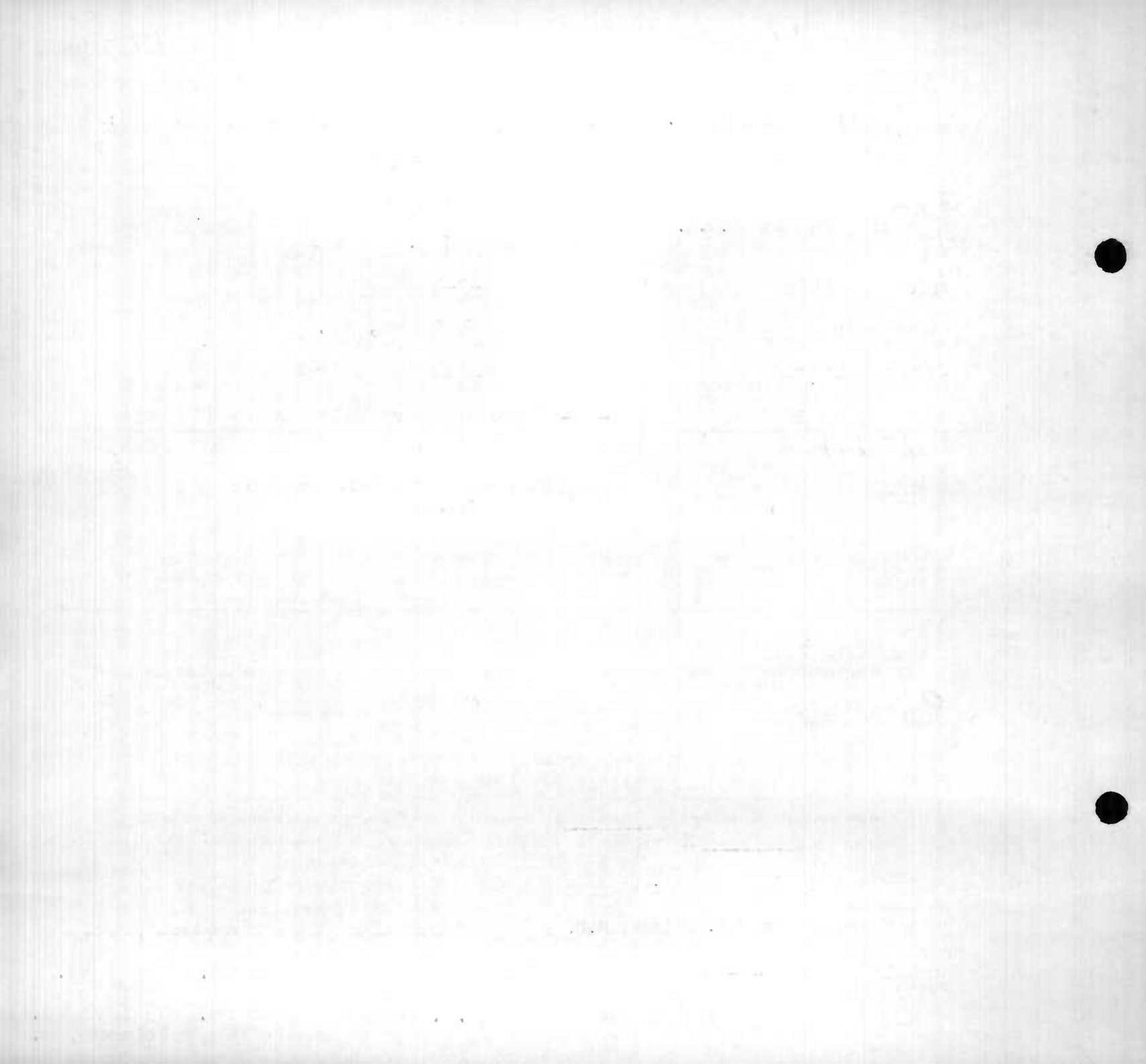
24C. FUNERAL DIRECTOR

Milton E. Elickson 1129 N. Calver St



| B-416 | | 67 10454 | | BALTIMORE CITY HEALTH DEPARTMENT | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. 67 10454 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
JACOB BALBIER Jr. | | | 2. DATE AND HOUR PRONOUNCED DEAD
October 31, 1967 11:50 p.m. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

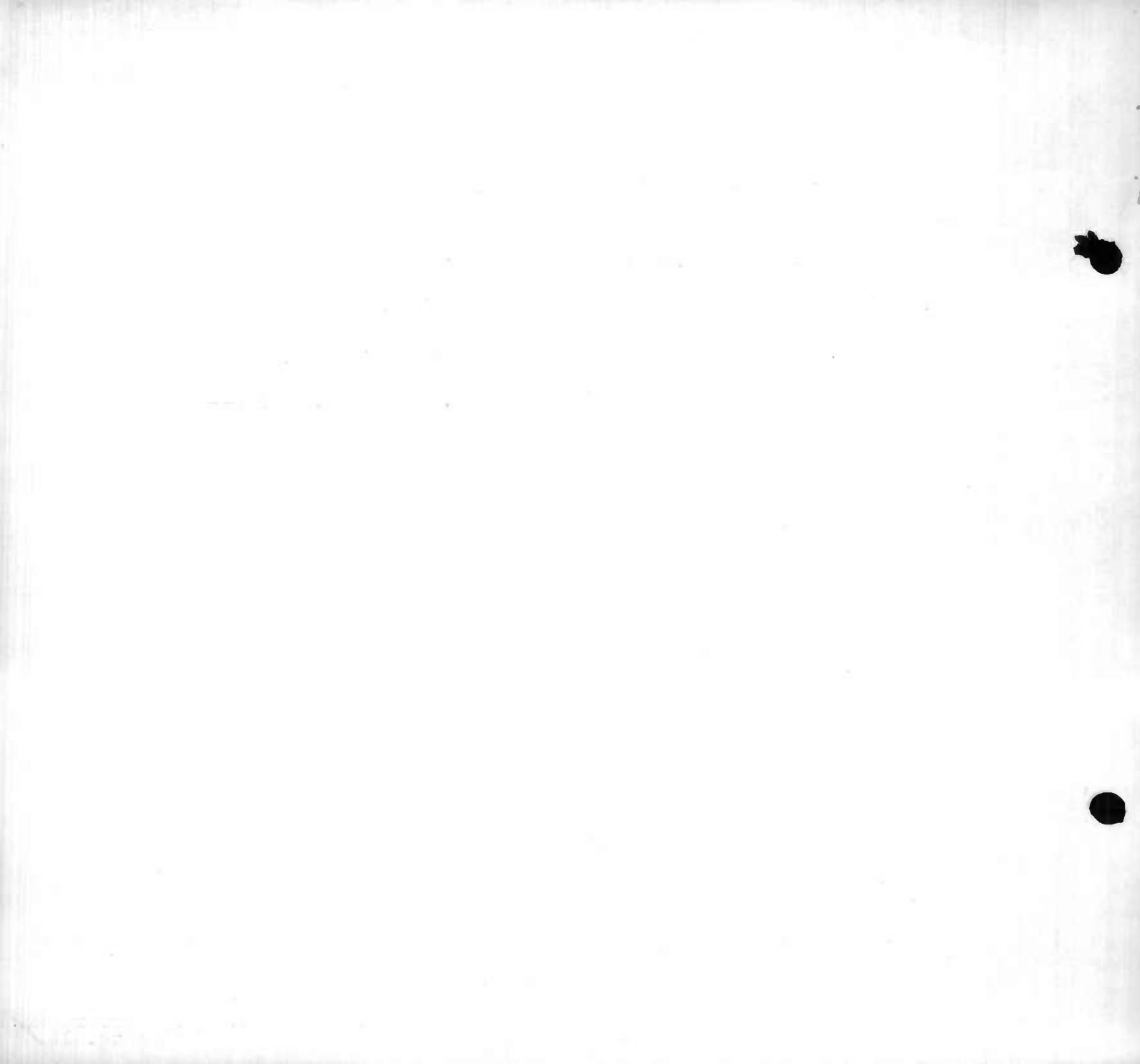
FULL NAME OF HOSPITAL OR INSTITUTION
32
89
Mercy Hospital D.O.A. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
512 E. 35th Street | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
5-7-1909 | 9. AGE (In years last birthday)
58 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY
Steel | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 13. FATHER'S NAME
Jacob Balbier | | | 14. MOTHER'S MAIDEN NAME
Madeline Schirgang | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
Yes WW 11 | | 16. SOCIAL SECURITY NO.
215-05-4245 | | 17. INFORMANT
Anna Mary Balbier | |
| 18. 422.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Edward F. Wilson M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) Edward F. Wilson, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED November 1, 1967 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
11-4-67 | | 23C. NAME OF CEMETERY or CREMATORY
Dulaney Valley | |
| 23D. LOCATION
Baltimore Co. | | 23E. LOCATION
Baltimore Co. | | 23F. LOCATION
Md. | |
| 24A. DATE REC'D BY HEALTH DEPT.
NOV 2 1967 | | 24B. NAME OF REGISTRAR
Robert E. Fisher | | 24C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | |
| 24D. ADDRESS
4905 York Rd. | | 24E. ADDRESS
Baltimore, Md. | | 24F. ADDRESS
Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

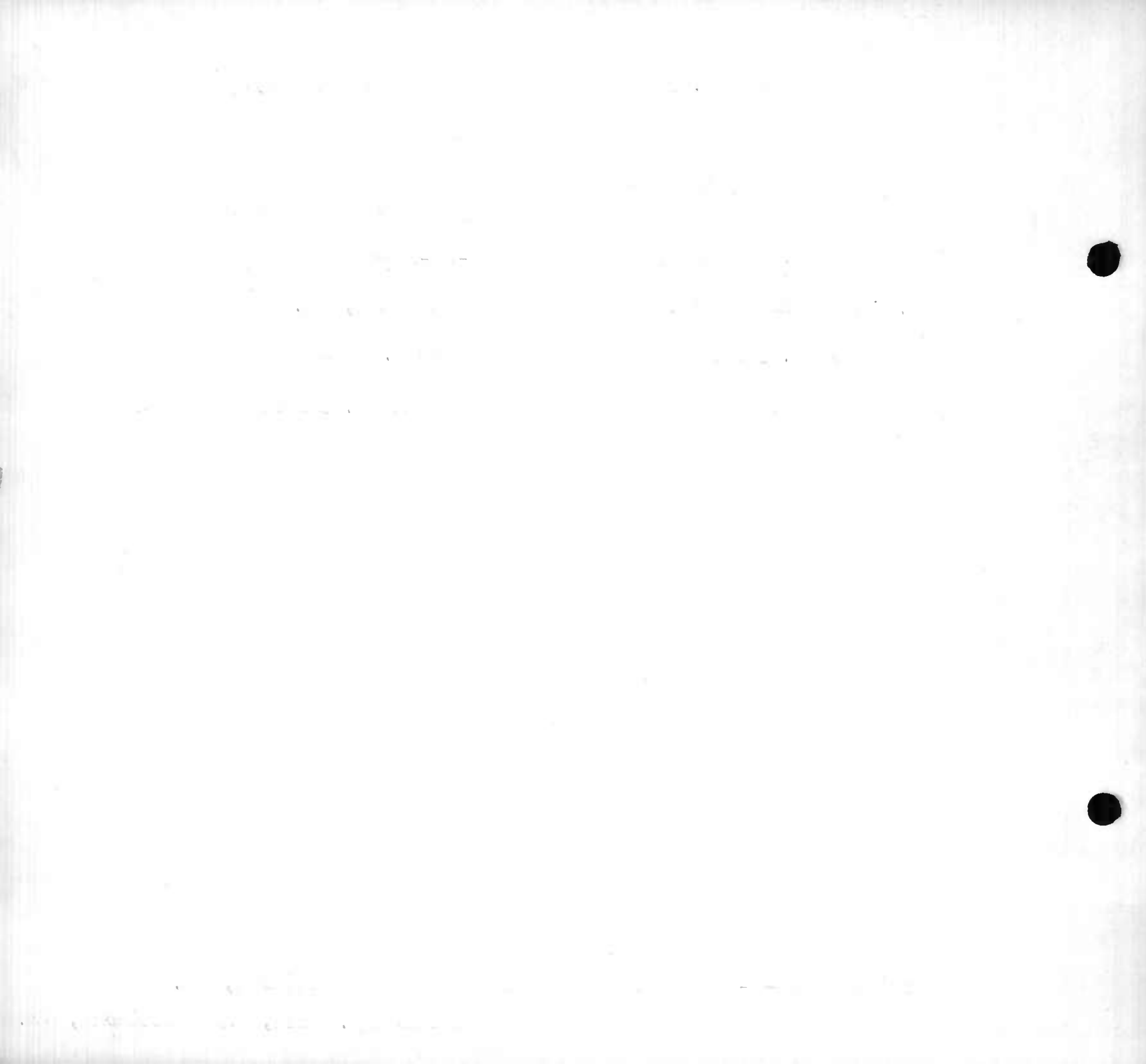
| D-120 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10455 | |
|---|---------------|--|----------------------------|--|--|--|--|
| BIRTH NO. 67 10455 | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) FREDERICK DeBUS | | | | 2. DATE AND HOUR OF DEATH Nov. 1, 1967 10:30 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4014 Walnut Ave. 00 | | | | A. STATE Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give town or township) Baltimore 27-05 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 4014 Walnut Ave. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7/19/1898 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cream Tester | | 10B. KIND OF BUSINESS OR INDUSTRY Chesapeake Creamery Maryland | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John H. DeBus | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Bennazar | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216035627 | | 17. INFORMANT Mrs. Bessie J. DeBus-- Same | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Carcinomatosis DUE TO (B) Carcinoma Anaplastic DUE TO (C) probably from pancreas | | INTERVAL BETWEEN ONSET AND DEATH 2 3 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 9/26/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED non-functioning Gall Bladder | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 9/7 1967 to 11/1 1967, that (I) (we) last saw the deceased alive on 10/31 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Paul G. Mueller | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 11/1/67 | |
| 23C. PHYSICIAN'S NAME (Type) PAUL G. MUELLER | | | | 23D. ADDRESS M.D. 6411 Belair Rd Balto Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 11/4/67 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. NOV 2 1967 | | 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. Balto. 14 | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|--|------------------|--|--|
| BIRTH NO. 7-430 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10456 | |
| M.E. CASE NO. | | 67 10456 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Harry E. Flautt | | October 31, 1967 | | 11:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Union Memorial Hospital | | A. STATE
Md | | B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | 27-01 | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 3202 Berkshire Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| male | white | married | 8-14-1898 | 69 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Ret. Stationary Engineer | | | | Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| USA | | Clifton A. Flautt | | Emma M. Myers | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| yes | | WW 1 | | Mrs Mary E. Flautt | |
| | | | | same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) | | (A) Coronary Occlusion | | Few minutes | |
| ANTECEDENT CAUSES | | (B) Coronary Artery Disease | | 3 years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 19 64 to October 19 67 , that (I) (we) lost saw the deceased olive an October 26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Loy M. Zimmerman | | | | 10/31/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Loy M. Zimmerman | | 3202 Harford Rd. Baltimore, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| burial | | 11-3-67 | | Woodlawn Cemetery | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| NOV 2 1967 | | Robert E. Finkbeiner | | Leonard J. Ruck, Inc Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|----------------------|---|-----------------------------|--|---|--|--|
| M-635 | | 67 10457 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10457 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Charles L. Martin | | 11-1-67 16:35/p M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
48 Maryland General Hospital | | | | A. STATE
Maryland B. COUNTY
Baltimore | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 27-38 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
1435 Cedarcroft Road | | | |
| 5. SEX
MALE | 6. RACE
CAUCASIAN | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
5-19-08 | 9. AGE (In years lost birthday)
59 | If Under 1 Yr.
Months: Days: Hours: Min. | If Under 24 Hrs.
Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CLERK | | 10B. KIND OF BUSINESS OR INDUSTRY
B&O RR | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
United States | |
| 13. FATHER'S NAME
Harry Martin | | | | 14. MOTHER'S MAIDEN NAME
EMMA A. Chesney | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW2 | | 16. SOCIAL SECURITY NO.
705-03-1191 | | 17. INFORMANT
Mrs. Marie E. Martin | | ADDRESS
(Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
420.1 I
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (A) <u>Cornary thrombosis</u>
DUE TO
(B) <u>Atherosclerosis</u>
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/30 1967 to 11/1 1967, that (I) (we) lost saw the deceased alive on 11/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Daniel E. Wilkerson | | | | | | 23B. DATE SIGNED
11/1/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Daniel E. Wilkerson | | | | | | 23D. ADDRESS
M.D. 1410 Baltn St | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/4/67 | | 24C. NAME OF CEMETERY OR CREMATORY
Memorial Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 2 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|--|--|
| BIRTH NO.
67 10458 | | BALTIMORE CITY HEALTH DEPARTMENT
REGISTERED NO. 67 10458 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Richard F. Brown</i> | |
| 2. DATE AND HOUR OF DEATH
<i>October 30, 1967 8⁵⁰ A.M.</i> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>37 Mercy Hospital</i> | | (If not in hospital or institution, give street address or location) | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>Baltimore</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i>
D. STREET ADDRESS (If rural, give location)
<i>1723 Kennoway Rd.</i> | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Never married</i> | 8. DATE OF BIRTH
<i>5-17-05</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Counter man-ret.</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Restaurant employ</i> | 9. AGE (in years last birthday)
<i>62</i> |
| 11. BIRTHPLACE (State or foreign country)
<i>U.S.A. - Ohio</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<i>Richard Franklin Brown, Sr.</i> | | 14. MOTHER'S MAIDEN NAME
<i>Hattie Burton</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)
<i>Yes</i> | | 16. SOCIAL SECURITY NO.
<i>577-22-2561</i> | |
| 17. INFORMANT
<i>Family records</i> | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO <i>organic Brain Syndrome. Undetermined.</i>
(B) DUE TO
(C) <i>Subarachnoid hemorrhage</i> 5 months. | |
| INTERVAL BETWEEN ONSET AND DEATH | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Pulmonary Edema -</i> | |
| 19A. DATE OF OPERATION
<i>2 -</i> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
<i>yes -</i> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>yes -</i> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/27/67</i> 19 <i>67</i> to <i>10/30</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>10/30/67</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>O. Polanco</i> | | 23B. DATE SIGNED
<i>10/31/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Octavio Polanco</i> | | 23D. ADDRESS
<i>Mercy Hospital, Balto, Md.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | 24B. DATE
<i>Nov. 2, 1967</i> | 24C. NAME OF CEMETERY OR CREMATORY
<i>Baltimore National Cemetery</i> | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>NOV 3 1967</i> | 25B. NAME OF REGISTRAR
<i>John E. Feltner</i> | 25C. FUNERAL DIRECTOR
<i>John Burns' Sons, Towson, Maryland</i> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | Registered No. 67 10459 | |
|--|-----------------------------|--|---|--|--|
| BIRTH NO. 67 10459 | | | | | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) STEPHEN, NELL P | | | 2. DATE AND HOUR OF DEATH
NOVEMBER 1, 1967 12:15P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL
(If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1209 BIRCH AVE. 21227 | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
6/28/16 | 9. AGE (In years lost birthday)
51 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE/ Agent | | 10B. KIND OF BUSINESS OR INDUSTRY
Real Estate Sales | | 11. BIRTHPLACE (State or foreign country)
SOUTH CAROLINA | |
| 13. FATHER'S NAME
Wm OSCAR PARRIS | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NONE | | | 16. SOCIAL SECURITY NO.
248-14-8326 | | 17. INFORMANT ADDRESS
ST. AGNES HOSPITAL RECORDS |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
330XI
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | CAUSE OF DEATH
(A) Cerebral Edema Post op
DUE TO
(B) spontaneous, subarachnoid hemorrhage
DUE TO
(C) left internal Carotid aneurysm | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 22. I certify that (I) (this hospital) attended the deceased from OCTOBER 19 1967 to NOVEMBER 1 1967 , that (I) (we) last saw the deceased alive on NOVEMBER 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Mohammad Nickbakht M.D. | | | | 23B. DATE SIGNED
11-1-67 | |
| 23C. PHYSICIAN'S NAME (Type)
MOHAMMAD NICKBAKHT M.D. | | | | 23D. ADDRESS
ST. AGNES HOSP; CATON & WILKENS AVES. 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
11/4/67 | 24C. NAME of CEMETERY or CREMATORY
Meadowridge Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE RECD BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10460 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. 67 10460 | |
|---|---------------------|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) SYLVIA ROSS | | | | 2. DATE AND HOUR OF DEATH
6:30 10/29/67 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSPITAL of BALTO. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Carroll Co. | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 56-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
WINER RD. FINKSBURG, MD | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH
9/6/00 | 9. AGE (In years last birthday)
67 | If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
-- | | 11. BIRTHPLACE (State or foreign country)
Dover, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Thomas Turnbaugh | | | | 14. MOTHER'S MAIDEN NAME
Annie Hare | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-36-1593 | | 17. INFORMANT ADDRESS
Niner Road, Finksburg, Md. | | | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) Acute MYOCARDIAL INFARCTION
DUE TO
(B) A.S.C.V.D
DUE TO
(C) DIABETES Mellitus, Hypertension | | INTERVAL BETWEEN ONSET AND DEATH
1 day
?
? | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
10/29 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from 10/29 1967 to 10/29/1967 , that (I) (<u>we</u>) last saw the deceased alive on 10/29 1967 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did not</u>) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Alan F. Wore | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10/29/67 | |
| 23C. PHYSICIAN'S NAME (Type)
ALAN F. WORE | | | | 23D. ADDRESS
90 SINAI HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/2/67 | | 24C. NAME OF CEMETERY or CREMATORY
Evergreen Mem. Gardens | | 24D. LOCATION (City, town, or county) (State)
Finksburg, Carroll Co., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
H. J. Schhardt | | ADDRESS
Owings Mills, Md. | |

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FUNERAL DIRECTOR: IMPORTANT

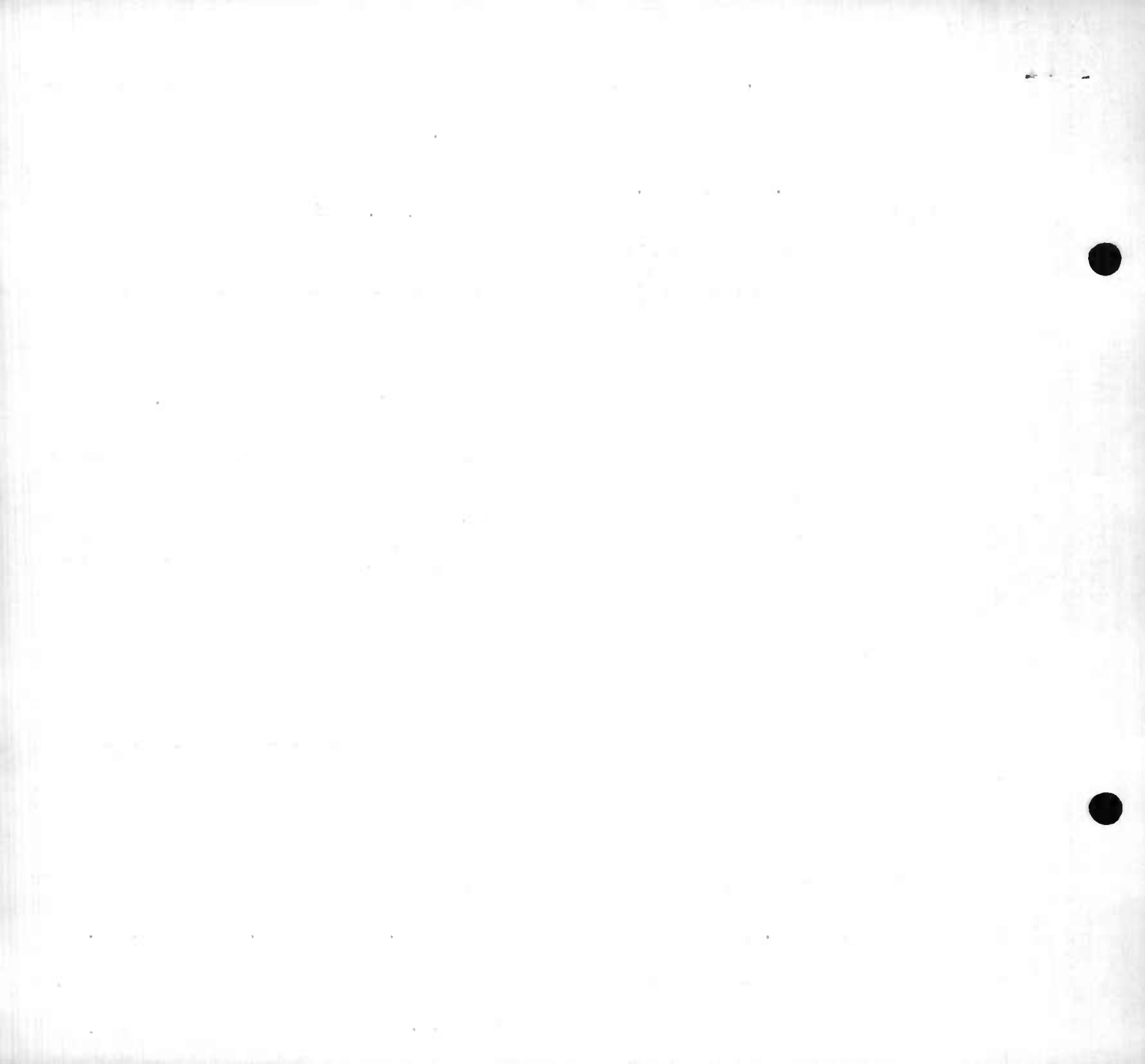
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10461 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10461 | |
|---|---------|--|-----------------------------------|--|---|--|------------------------------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | Rudolph Chovanec | | October 29, 1967 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 90 Lake Drive Nursing Home | | | | Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 3701 Second Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| Male | White | Widowed | Aug. 12, 1875 | 92 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Butcher | | | | | Czechoslovakia | | ? |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Anthony Chovanec | | | | ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | 219-54-3572 | | Mrs. Ida Campanella same address as #3 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | Brouchopneumonia (aspiration) | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | Cerebral Arteriosclerosis (senility) | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | ASCVD - CHF | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2 - 27 - 1967 to 10 - 29 - 1967, that (i) (we) lost saw the deceased alive on 10 - 29 - 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| CESAR VALLE CAVERO | | | | | | 11-1-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| CESAR VALLE CAVERO | | | | 8629 Liberty Rd | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 11/2/67 | | Loudon Park Cemetery | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | | |
| NOV 3 1967 | | Robert E. Fisk | | Wm. F. Fisk Sons Baltimore, Md. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10462 | |
|--|-----------------------------|--|---|--|--|
| BIRTH NO. | | 67 10462 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Elmeda M. MARSHALL | | 2. DATE AND HOUR OF DEATH
Oct 31/1967 12⁵⁵ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 422 N. Robinson St. | | A. STATE
Md. | | B. COUNTY | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | 6-01 | |
| | | D. STREET ADDRESS (If rural, give location)
422 N. Robinson | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced | 8. DATE OF BIRTH
July 19 1885 | 9. AGE (In years last birthday)
82 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (State or foreign country)
Indiana | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Joseph Willis | | 14. MOTHER'S MAIDEN NAME
Sarah Murray | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216 36 3005 | | 17. INFORMANT ADDRESS
Edna DeHaven 16 Chesapeake Ave. 21204 | |
| 18. 464X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Coronary Thrombosis | | CAUSE OF DEATH
(A) DUE TO
cerebro-vascular disease | | INTERVAL BETWEEN ONSET AND DEATH
1 day | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Phlebitis | | (B) DUE TO
2 wks | | | |
| (C) | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/10 19 62 to 10/31 19 67 , that (I) was last saw the deceased alive on 10/17 19 67 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | |
| 23A. SIGNATURE
Louis F. Klimes | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10/31/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Louis F. Klimes | | 23D. ADDRESS
M.D. 2623 E. Monument St. Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
11-1-67 | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland Balto.Co | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
P. E. Johnson | | 25C. FUNERAL DIRECTOR
Wm. E. Johnson 8521 Loch Raven Blvd. | |



1
M-320

67 10463 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10463

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANK

MADDOX

2. DATE AND HOUR PRONOUNCED DEAD

October 27, 1967

4:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Smith's Boat Yard
6211 Pennington Avenue4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6211 Pennington Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Never

8. DATE OF BIRTH

6/23/03

9. AGE (in years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Boat Yard

10B. KIND OF BUSINESS OR INDUSTRY

Repairing boats

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

Julia Maddox Venton Maryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

None

16. SOCIAL
SECURITY NO.

I43-03-5211

17. INFORMANT

ADDRESS

Irene Jones Venton, Md

18. 2929.01

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Drowning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Water

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

6211 Pennington Avenue

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

UNK

UNK

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

UNK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Warner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

10/28/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

11/2/67

23C. NAME of CEMETERY or CREMATORY

Grace

23D. LOCATION

(City, town, or county)

Venton Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

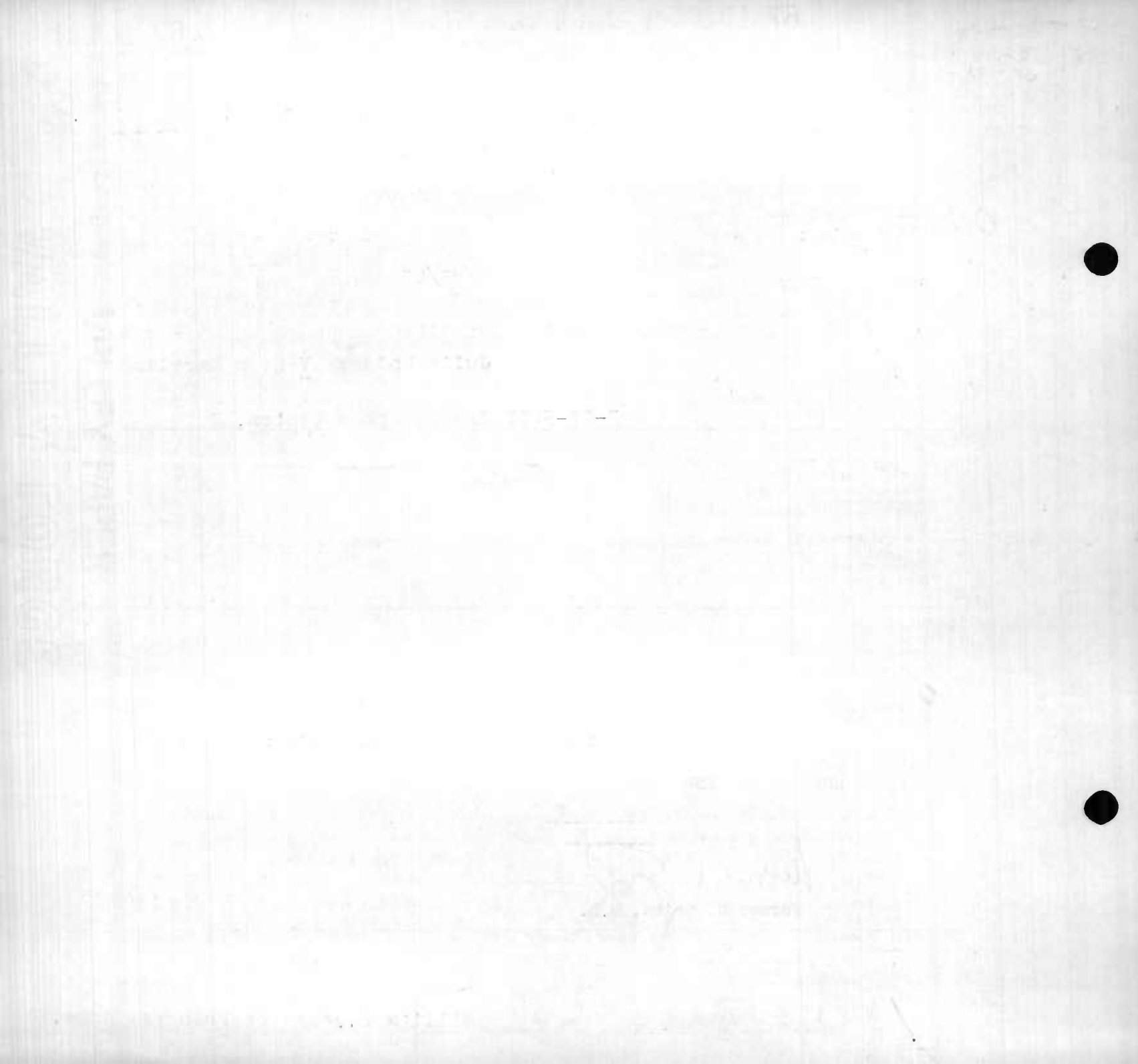
ADDRESS

NOV 3

1967

Robert E. Fairbank

William H. James Jr Princess Anne, Md



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10464 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10464 | |
|---|-------------------------|---|--|--|---|--|--|
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) LINDA HARRIS | | | | 2. DATE AND HOUR OF DEATH
OCTOBER 30, 1967 1:05 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
CHURCH HOME & HOSPITAL
35 | | (If not in hospital or institution, give street address or location) | | A. STATE
MARYLAND | | B. COUNTY
Balt. Co | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
53-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
27 FULLER AVE. | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
July 22, 1916 | 9. AGE (In years lost birthday)
51 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
Martins | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
THEODORE FLATT | | | | 14. MOTHER'S MAIDEN NAME
Augusta GELBERT | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-07-2454 | | 17. INFORMANT ADDRESS
MELVIN HARRIS 27 FULLER AVE | | | |
| 18. 331X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CEREBRO - VASCULAR ACCIDENT
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from OCTOBER 29 19 67 to OCTOBER 30 19 67 , that (I) (we) last saw the deceased alive on OCTOBER 30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Corazon Z. Vergara | | | | M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
OCTOBER 30 '67 | |
| 23C. PHYSICIAN'S NAME (Type)
CORAZON Z. VERGARA | | | | 23D. ADDRESS
M.D. CHURCH HOME & HOSPITAL 100 N. BROADWAY BALTIMORE MD. 21201 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-2-1967 | | 24C. NAME of CEMETERY or CREMATORY
Zion Lutheran Cemetery | | 24D. LOCATION (City, town, or county) (State)
Golden Ring Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farkner | | 25C. FUNERAL DIRECTOR
Lassahn Funeral Home | | ADDRESS
7401 Belair Road | |

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

10-10-50

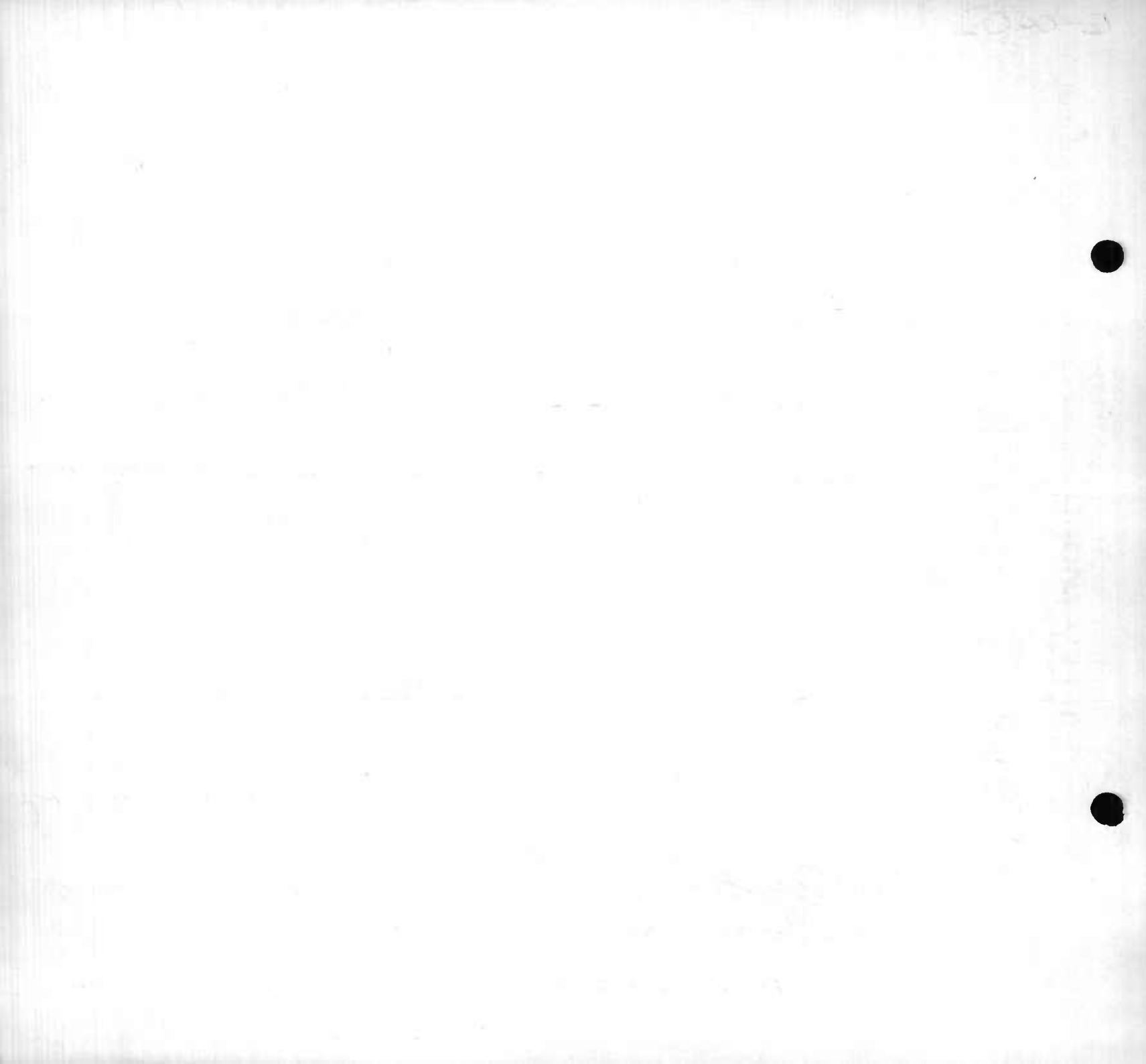
10-10-50

10-10-50

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

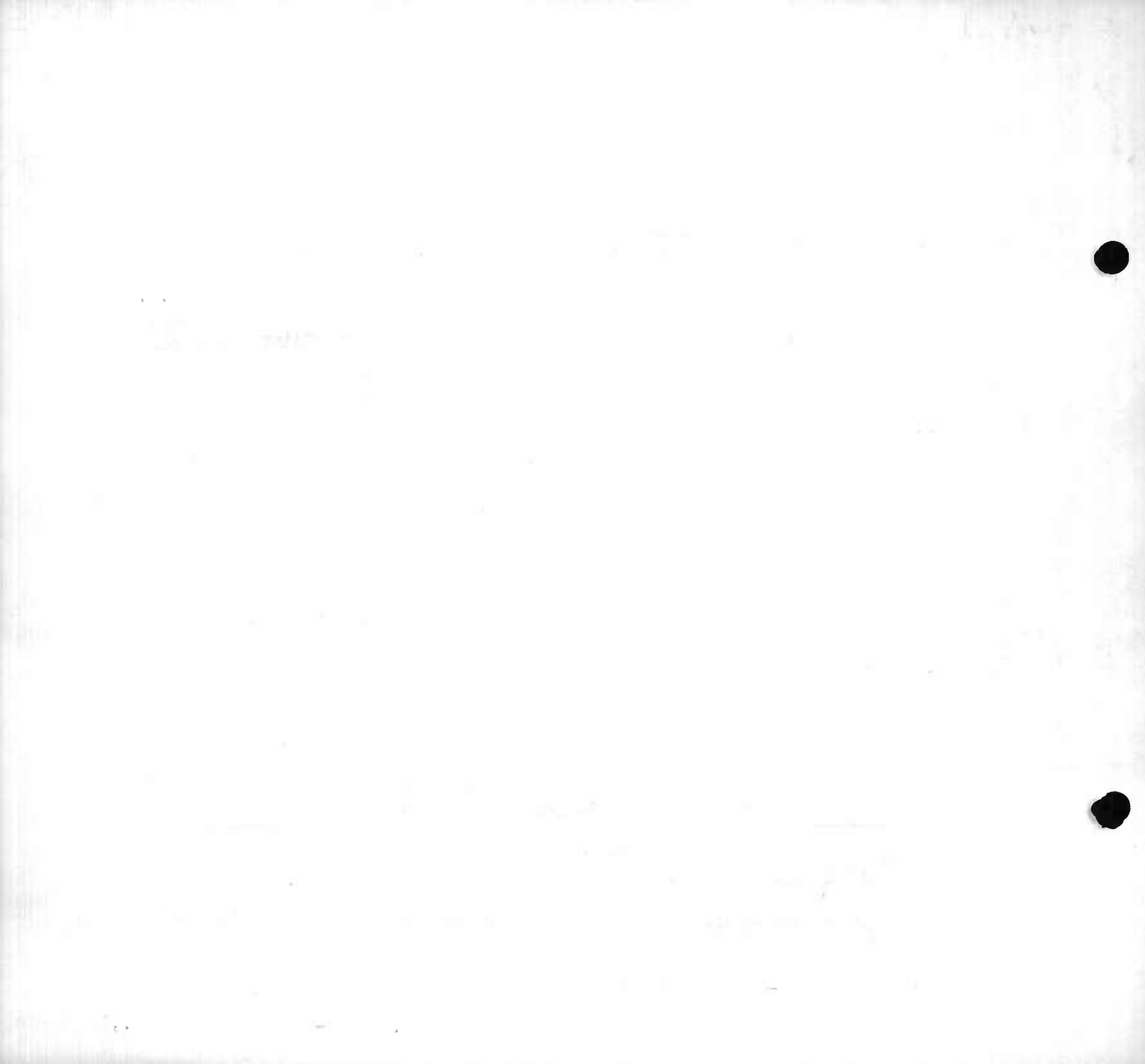
| BIRTH NO. 67 10465 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | Registered No. 67 10465 | |
|---|--|--|--|--|--|---|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | FABIAN J. LEE | | | | 10/28/67 3:30 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | A. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | md. | | | | B. COUNTY | |
| 34 Bon Secours Hospital | | | | Baltimore | | | | Belt Co. | |
| 5. SEX | | | | 6. RACE | | | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| MALE | | | | CAUCASIAN | | | | MARRIED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 8. DATE OF BIRTH | |
| SALES | | | | Paradise Lounge | | | | 7/25/10 | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | 9. AGE (In years last birthday) | |
| Maryland | | | | U.S. | | | | 57 | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| James Lee | | | | MARY I. HARTWELL | | | | YES WWII | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | |
| 214-63-0599 | | | | Mrs. Fabian J. Lee | | | | 36 Briarwood Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) CONGESTIVE HEART FAILURE | | | | THREE WEEKS | |
| ANTECEDENT CAUSES | | | | (B) MYOCARDIAL INFARCTION | | | | DIFFUSE | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | | | |
| II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (he) (this hospital) attended the deceased from Oct 6th 1967 to Oct 28th 1967, that (we) last saw the deceased alive on Oct 28th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| [Signature] | | | | M.D. | | | | OCT 28 1967 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) | |
| KYE YOUN KIM | | | | M.D. | | | | Burial | |
| 24B. DATE | | | | 24C. NAME OF CEMETERY OR CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | |
| 10-1-67 | | | | Baltimore National Cem. | | | | Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR | |
| NOV 3 1967 | | | | G. E. Farley | | | | Farley - Cavannah | |
| 25D. ADDRESS | | | | 25E. ADDRESS | | | | 25F. ADDRESS | |
| | | | | 6601 | | | | Fridman Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------------------|---|---|---|---|
| 67 10466 | | 67 10466 | | 67 10466 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) HELEN G. CLINE | | | 2. DATE AND HOUR OF DEATH
October 30, 1967 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
36 FRANKLIN SQUARE HOSPITAL | | | A. STATE MARYLAND - BALTO. | | |
| (If not in hospital or institution, give street address or location) | | | B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO | | |
| | | | D. STREET ADDRESS (If rural, give location)
2302 CEDLEY ST. | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED NEVER MARRIED
WIDOWED, DIVORCED (specify)
SEPARATED | 8. DATE OF BIRTH
July 3, 1892 | 9. AGE (In years lost birthday)
75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
JOHN HAYDEN | | 14. MOTHER'S MAIDEN NAME
MARTHA FREDERICKS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
CHART | |
| 18. 420.141260X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
DIABETIS MELLITUS - K-W DISEASE | | CAUSE OF DEATH
(A) VENTRICULAR FIBRILLATION
DUE TO
(B) CORONARY HEART DISEASE
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
45 min.
SEVERAL YEARS | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/29/67 19 to 10/30/67 19 that (I) (we) last saw the deceased alive on 10/30/67 19 10:15 P.M. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
P. MacAraeg Jr. | | | | 23B. DATE SIGNED
10/30/67 | |
| 23C. PHYSICIAN'S NAME (Type)
P. MACARAEG JR. | | | | 23D. ADDRESS
FRANKLIN SQUARE HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-2-1967 | | 24C. NAME OF CEMETERY or CREMATORY
Lorraine Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Talbott | | 25C. FUNERAL DIRECTOR
George J. Gonce-11001 Ritchie Hwy., Baltimore | |



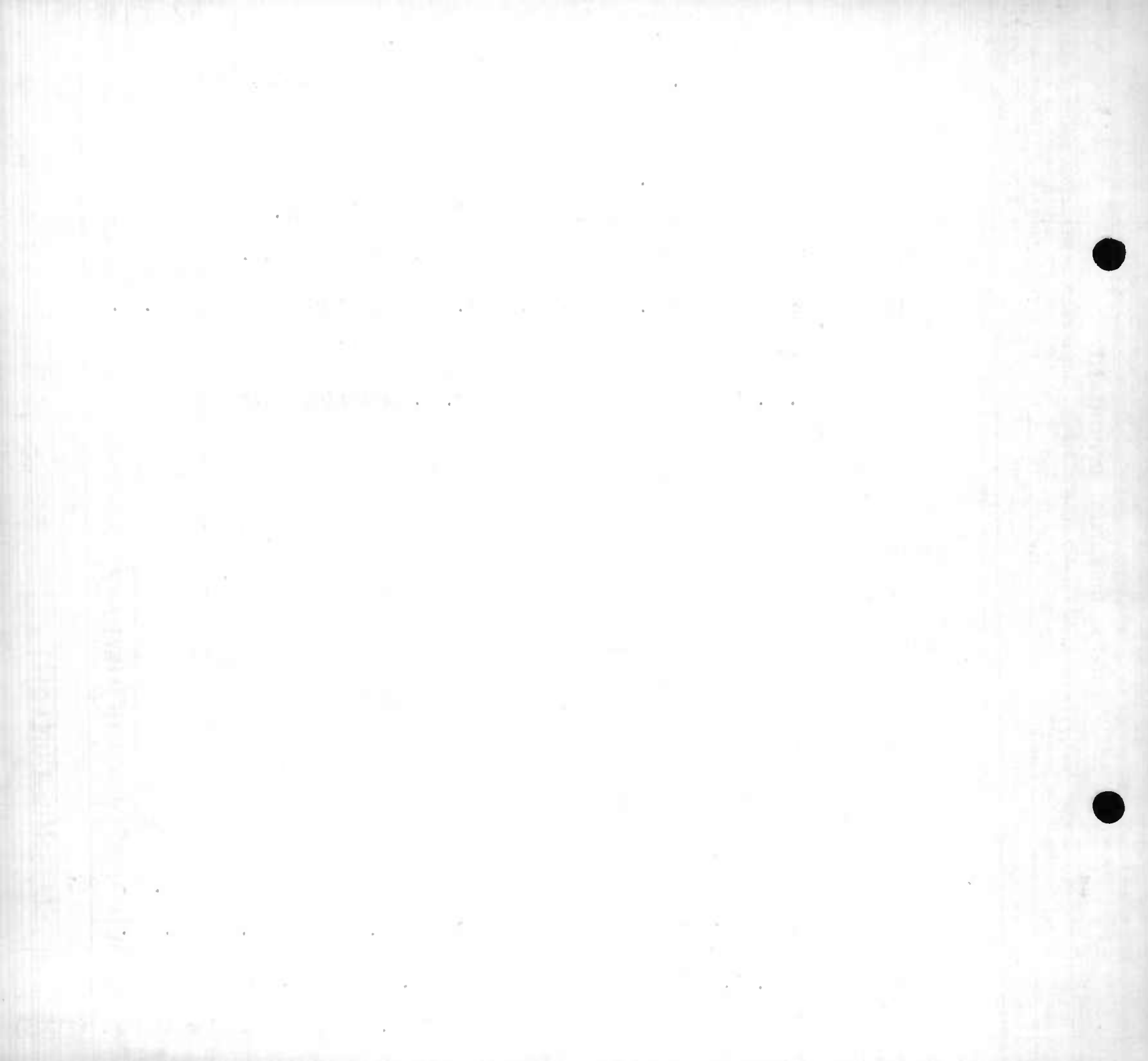
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|--|---|---|
| BIRTH NO. 67 10467 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10467 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) WILLIAM L. LEARY | | | 2. DATE AND HOUR OF DEATH
October 31, 1967 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
00 3710 Brooklyn Ave. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3710 Brooklyn Ave. | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
May 27, 1896 | 9. AGE (In years last birthday)
71 yrs. | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Fire fighter | | 10B. KIND OF BUSINESS OR INDUSTRY
Balto. City Fire. Dept. Connecticut | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
James Leary | | | 14. MOTHER'S MAIDEN NAME
Amelia Price | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes W. W. I | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mrs. M. Catherine Leary | |
| | | | | ADDRESS
Same | |
| 18. 332X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first. | | | CAUSE OF DEATH
(A) Cerebral Thrombosis
DUE TO
(B) Generalized arteriosclerosis
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
June 4/24/67
2 |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/24 1967 to 10/31 1967 , that (I) (we) last saw the deceased alive on 10/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Harry Deibel M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED
Nov. 1, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
Harry Deibel M.D. | | | 23D. ADDRESS
3226 S. Hanover St. Balto. Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Nov. 3, 1967 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
George J. Gonce | |
| | | | | ADDRESS
4001 Ritchie Hwy. (21225) | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|----------------------|---|---|--|---|
| 67 10468 | | 67 10468 | | | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Joseph G. Simonaitis | | | October 31, 1967 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)

450 S. Bentalou St. 21223 | | | A. STATE
Md. | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location)
450 S. Bentalou St. 21223 | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
10/15/10 | 9. AGE (In years last birthday)
57 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Key Worker Plant | | 10B. KIND OF BUSINESS OR INDUSTRY
National Industries | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
- - Simonaitis | | | |
| 14. MOTHER'S MAIDEN NAME
Anna - - - | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
218-03-4714 | | 17. INFORMANT
Mrs. Mildred A. Simonaitis, 450 S. Bentalou St. 21223 | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

18. 340.31
Cerebral thrombosis instant
Chronic arteriosclerosis - 14 years
dilatation
Hypertensive vascular dis. 2 years | | | | | |
| 19A. DATE OF OPERATION
0 | | | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | |
| 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No | | | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>67</u> to <u>Oct. 31</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct. 30</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Christian S. Mass</u> | | M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>11/1/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
XXXXXXXXXX
CHRISTIAN S. MASS, M.D. | | 23D. ADDRESS
687 Baltimore National Pike | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
11/4/67 | 24C. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10469 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10469 | |
|--|---------------------|---|--|---|--|--|---|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) <i>Birmingham, Mr. Thomas</i> | | 2. DATE AND HOUR OF DEATH
<i>11-1-67 7:15 A. M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <i>MD.</i> B. COUNTY <i>Baltimore Co.</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>34 Bon Secours Hospital</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore 53-00</i> | | | |
| D. STREET ADDRESS (If rural, give location)
<i>3515 Milford Mill Rd.</i> | | | | | | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widower</i> | 8. DATE OF BIRTH
<i>7-26-81</i> | 9. AGE (In years lost birthday)
<i>86</i> | If Under 1 Yr.
Months Days | If Under 24 Hrs.
Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Barber</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Hair Cutting</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Scotland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> |
| 13. FATHER'S NAME
<i>Birmingham, James</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Welford, Eliza</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Unknown</i> | | | 16. SOCIAL SECURITY NO.
<i>216-09-2756</i> | | 17. INFORMANT
<i>Mrs Mildred Berger</i> | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <i>Cerebrovascular Insufficiency</i>
DUE TO
(B) <i>Coronary Insufficiency</i>
DUE TO
(C) <i>Arteriosclerosis</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>4 years</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/28</i> 19 <i>67</i> to <i>11/1</i> 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>10/31</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Abraham</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>11/1/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>CESAR A. BRAD</i> | | | | 23D. ADDRESS
<i>Bon Secours Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11/4/67</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Loudon Park</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Balto. Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>NOV 3 1967</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Jenkins</i> | | 25C. FUNERAL DIRECTOR
<i>Loring Byers</i> | | | |
| | | | | ADDRESS
<i>8728 Liberty Rd Randalltown</i> | | | |

200 - 100 - 1000

200 - 100 - 1000

200 - 100 - 1000

1
S-315

67 10470 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10470

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JEFF T. STEVENS

2. DATE AND HOUR PRONOUNCED DEAD

October 30, 1967 6:55 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

437 W. 24th Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 12-07
437 W. 24th Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

June 16, 1901

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

Richmond Engineering

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

224-03-0027

17. INFORMANT

Dave Stevens-437 W. 24th Street

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic Cardiovascular
DiseaseINTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 30, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

11-2-66

23C. NAME OF CEMETERY or CREMATORY

Bermuda Memorial

23D. LOCATION

(City, town, or county)

(State)

Buckingham County

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

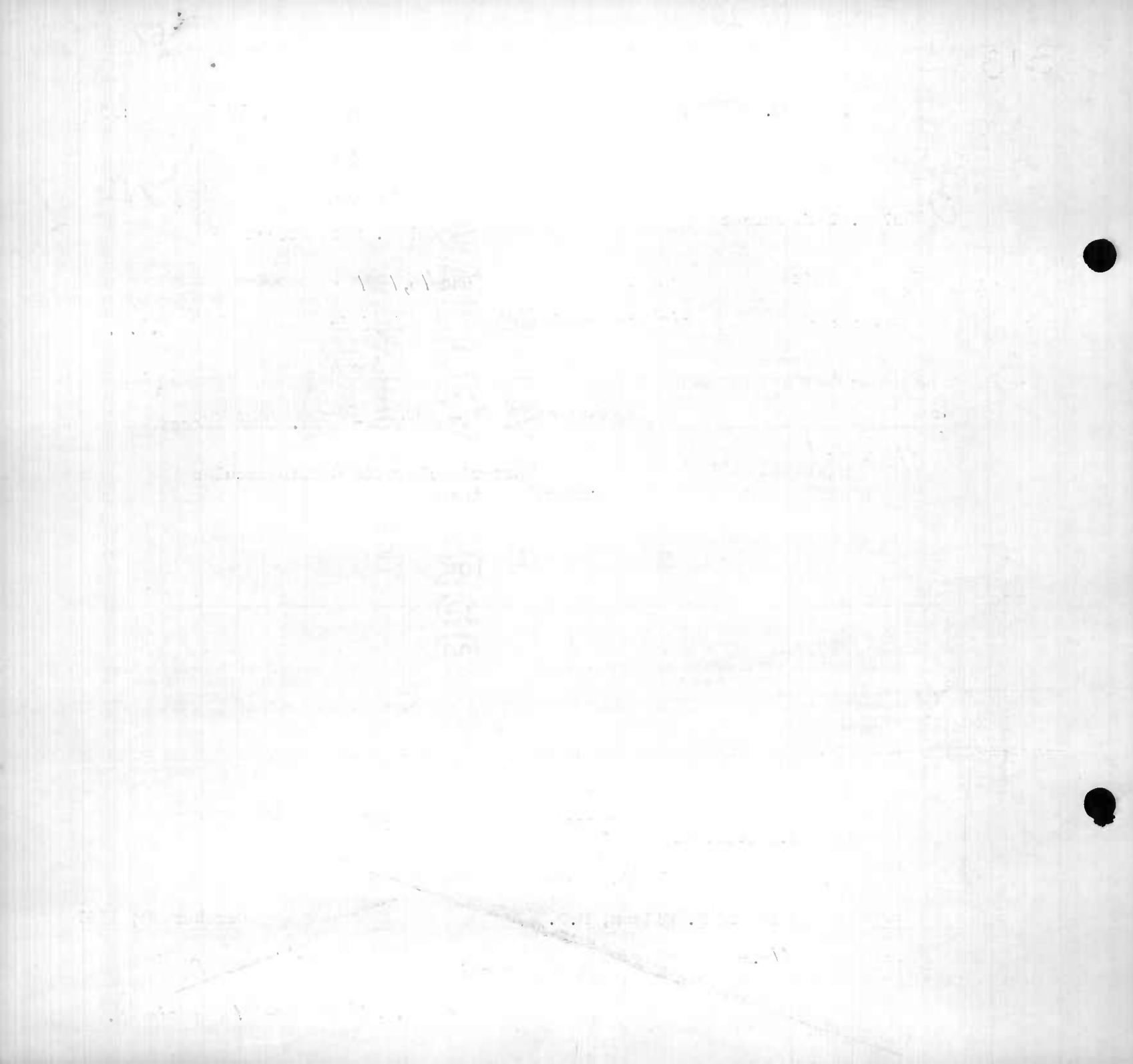
24C. FUNERAL DIRECTOR

ADDRESS

NOV 3 1967

R. E. F. Wilson

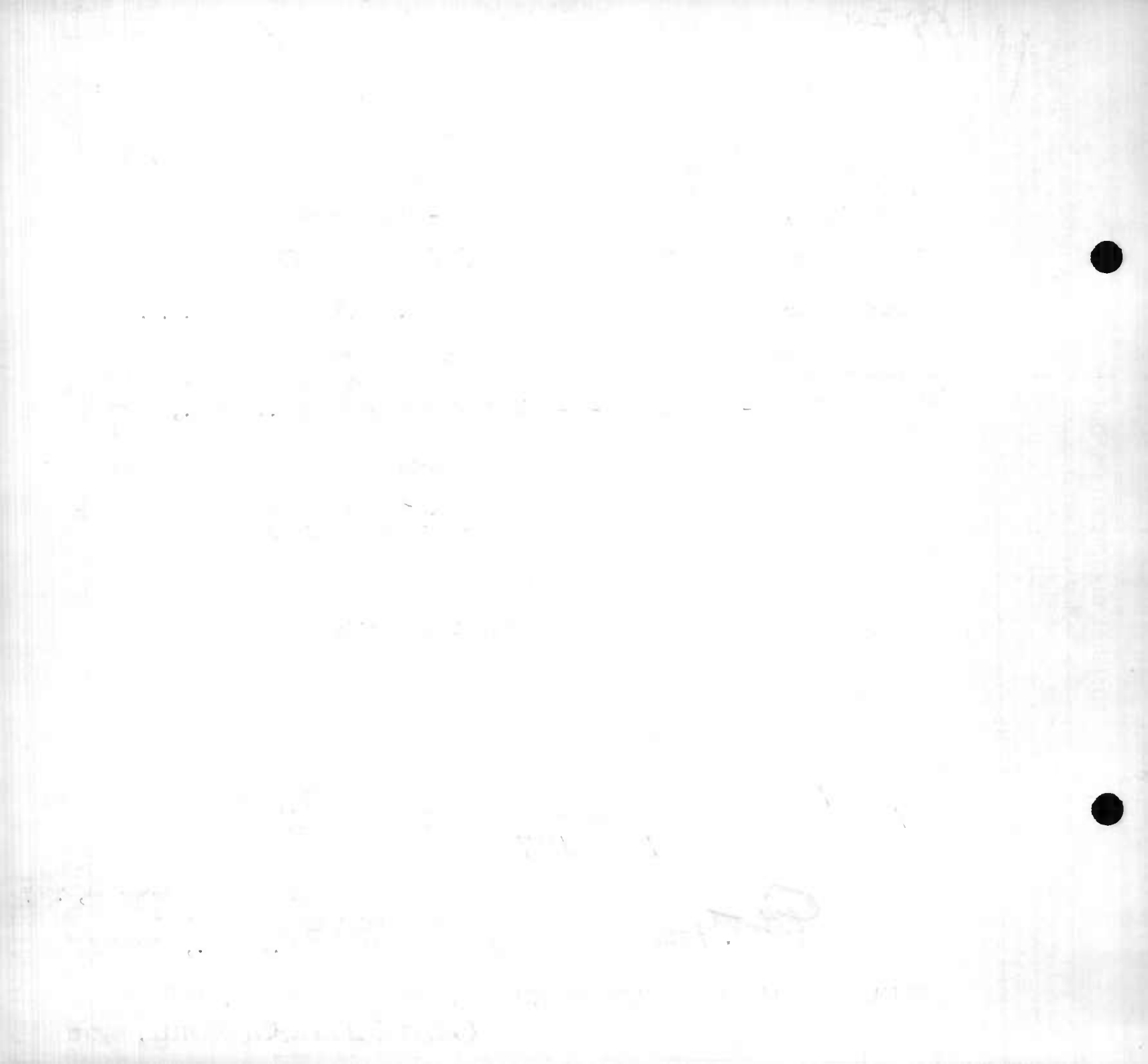
John C. Miller Inc-6415 Belair Rd.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-------------------------|---|------------------------------------|--|-------------------------------|---|--|
| BIRTH NO. m-200 | | 67 10471 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10471 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) MACK, CORNELIUS CARROLL | | | |
| 2. DATE AND HOUR OF DEATH
10/28/67 10:00 A.M. | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
27 Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Prince George Co. | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Laurel | | | | D. STREET ADDRESS (If rural, give location)
618 - 10th Street | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
1/28/08 | 9. AGE (In years last birthday)
59 | If Under 1 Yr.
Months Days | If Under 24 Hrs.
Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Truck Driver | | 10B. KIND OF BUSINESS OR INDUSTRY
unknown | | 11. BIRTHPLACE (State or foreign country)
Laurel, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Walter W Mack | | | | 14. MOTHER'S MAIDEN NAME
Grace Soleman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 11/22/43 - 1/31/46 | | 16. SOCIAL SECURITY NO.
705-12-1795 | | 17. INFORMANT ADDRESS
Veterans Administration Hospital Records
3900 Loch Raven Blvd., Balto., Md 21218 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
130X1 | | | | CAUSE OF DEATH
(A) Carcinomatosis
DUE TO
Carcinoma of the Esophagus with
(B) metastasis to the liver
DUE TO
(C) | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH
6 months
6 months | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Pneumonia left side | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initiate medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from June 9th 1967 to October 29th 1967 , that (1) (we) last saw the deceased alive on October 29th 1967 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) view the body after death. | | | | | | | |
| 23A. SIGNATURE
ERNESTO P. SMITH | | | | | | 23B. DATE SIGNED
October 30, 1967 | |
| 23C. PHYSICIAN'S NAME (Type)
ERNESTO P. SMITH | | | | | | 23D. ADDRESS
Veterans Administration Hospital
3900 Loch Raven Blvd., Balto., Md 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
11/2/67 | | 24C. NAME of CEMETERY or CREMATORY
BALTIMORE NATIONAL CEMETERY | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR
Robert L. Snowden | | ADDRESS
ROCKVILLE, MARYLAND | |



FUNERAL DIRECTOR: IMPORTANT

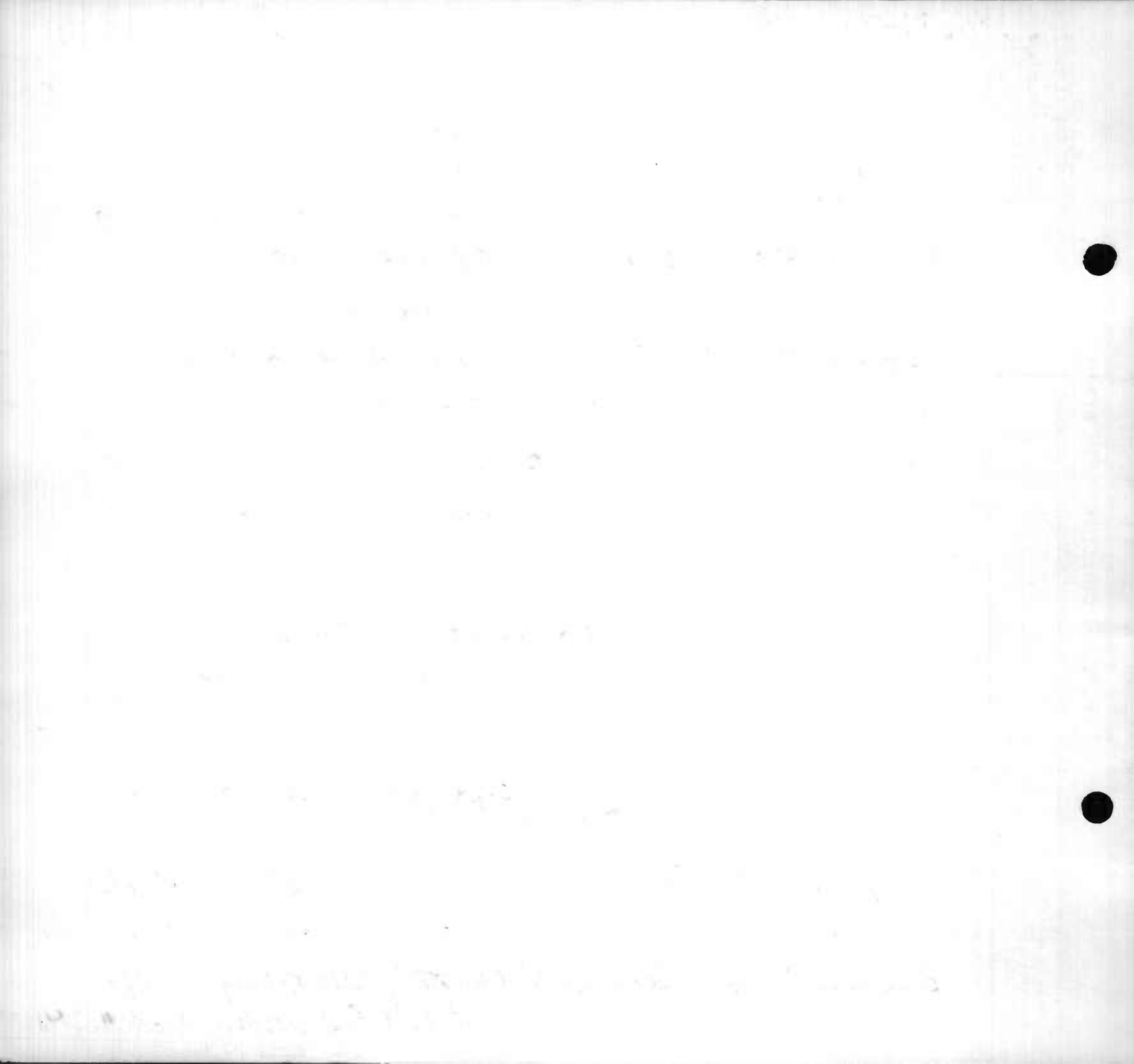
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-------------------------|--|--|
| N-213
BIRTH NO. 67 10472 CERTIFICATE OF DEATH Registered No. 67 10472 | | | |
| M.E. CASE NO.
1. NAME OF DECEASED (Type or Print) OLIVIA NESBITT | | 2. DATE AND HOUR OF DEATH
10/29/67 6:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
28 USPHS HOSPITAL BALTIMORE Md. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Montgomery Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
KENSINGTON 65000
D. STREET ADDRESS (If rural, give location)
4107 PLYERS MILL RD. | |
| 5. SEX
F | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
DIV. | 8. DATE OF BIRTH
5/3/18 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
49 |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JAMES H. WIMS | | 14. MOTHER'S MAIDEN NAME
ALTIA M. ONLEY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
UNK. | 17. INFORMANT
CHART |
| 18. 578X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) GANGRENE OF SMALL BOWEL
DUE TO
(B) FIBROUS ADHESIONS
DUE TO
(C) _____
INTERVAL BETWEEN ONSET AND DEATH
HRS.
YRS. | |
| II
OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
HODGKINS DISEASE | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 25 19 67 to Oct 29 19 67 , that (I) (we) last saw the deceased alive on Oct 29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Michael E. Pelczar | | 23B. DATE SIGNED
10/29/67 | |
| 23C. PHYSICIAN'S NAME (Type)
MICHAEL E. PELCZAR M.D. | | 23D. ADDRESS
USPHS HOSPITAL BALTIMORE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
11/1/67 | |
| 24C. NAME OF CEMETERY OR CREMATORY
John Wesley Cemetery | | 24D. LOCATION (City, town, or county) (State)
Clarksburg, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | |
| 25C. FUNERAL DIRECTOR
Robert L. Snowden | | ADDRESS
Rockville, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|--|---|---|
| BIRTH NO.
67 10473 | | BALTIMORE CITY HEALTH DEPARTMENT
Certificate of Death | | Registered No. 67 10473 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) <i>Mary F. Cowan</i> | | | 2. DATE AND HOUR OF DEATH
<i>11-2-67 12:30A M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>43 South Baltimore General Hosp</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>24-04</i>
D. STREET ADDRESS (If rural, give location) <i>1526 Covington St.</i> | | |
| 5. SEX
<i>F.</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Widow</i> | 8. DATE OF BIRTH
<i>9-17-1887</i> | 9. AGE (In years last birthday)
<i>80</i> | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>NONE</i> | | 11. BIRTHPLACE (State or foreign country)
<i>N.C.</i> |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | 13. FATHER'S NAME
<i>Lewis Fraley</i> | | |
| 14. MOTHER'S MAIDEN NAME
<i>Mary Sharp</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
<i>Family</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) state the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) <i>Senile Hemorrhage</i>
DUE TO <i>ARTERIAL EROSION IN</i>
(B) <i>ULCER OF HIATUS-HERNIA</i>
(C) <i>Senile Arteriosclerosis</i> | | |
| INTERVAL BETWEEN ONSET AND DEATH
<i>2 Weeks</i>
<i>2 Weeks</i>
<i>2 Weeks</i> | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION
<i>11-1-67</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Bleeding internally</i> | | 20A. AUTOPSY? (Yes or No)
<i>YES</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>YES</i> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that the (this hospital) attended the deceased from <i>10-30-1967</i> to <i>11-2-1967</i> , that it (we) last saw the deceased alive on <i>11-2-1967</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>Quasha</i> | | | 23B. DATE SIGNED
<i>11-2-67</i> | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Abdul G. Zureshi</i> | | | 23D. ADDRESS
<i>1213 Light St.</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11 4 67</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Cedar Hill</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Brooklyn, A. A. Co. Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>NOV 5 1967</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. Tanaka</i> | | | | 25C. FUNERAL DIRECTOR
<i>Mc Cully</i> | |
| ADDRESS
<i>130 E. Fort Ave</i> | | | | | |

1. The first part of the paper is devoted to a discussion of the

mathematical model of the system.

2. The second part of the paper is devoted to a discussion of the

experimental results.

3. The third part of the paper is devoted to a discussion of the

conclusions.

References

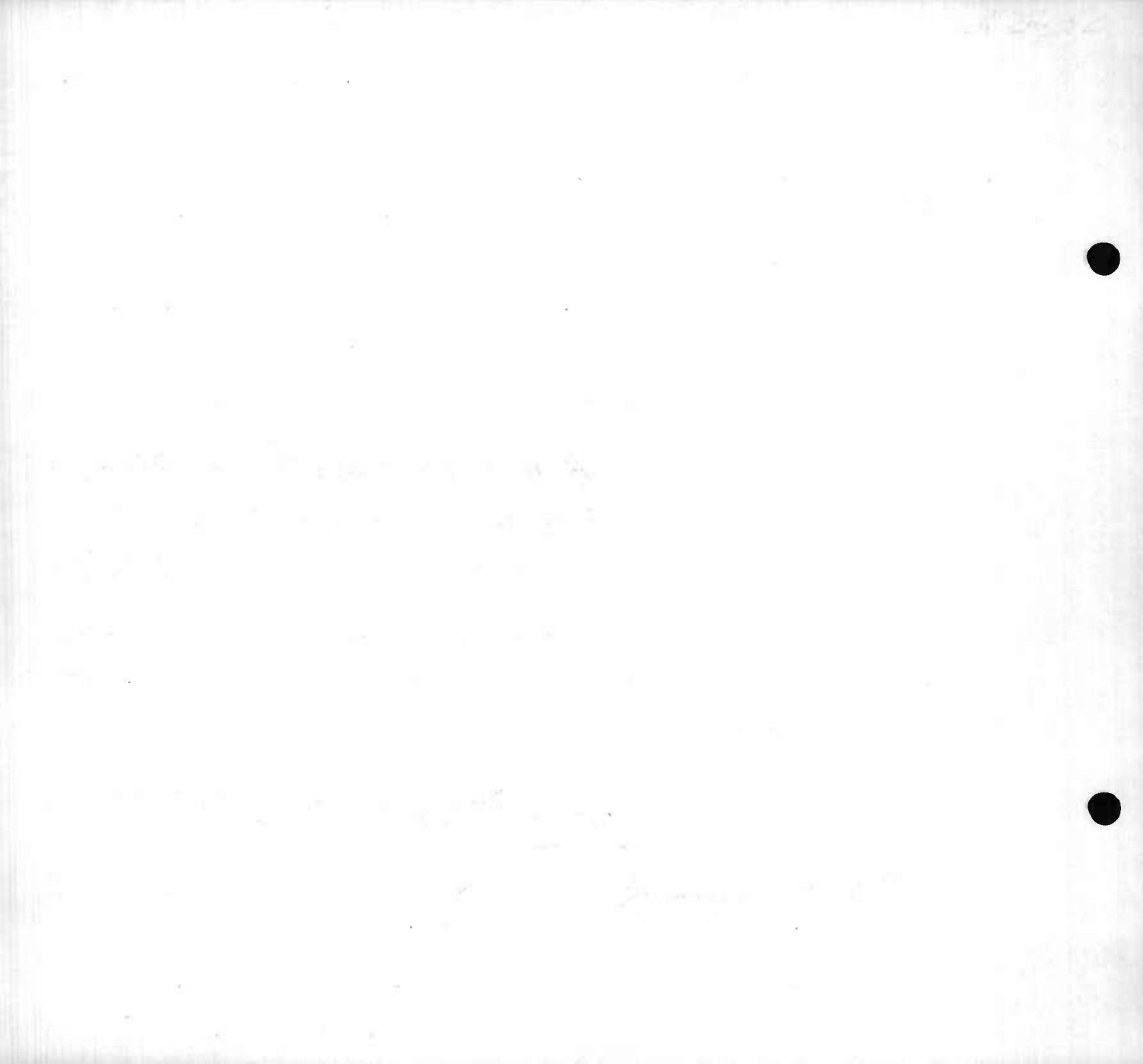
1. J. S. Ginzburg, *Usp. Fiz. Nauk*, **10**, 1 (1942).

2. J. S. Ginzburg, *Usp. Fiz. Nauk*, **10**, 1 (1942).

FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 10474 | | BIRTH NO. | |
|--|---------|--|-----------------------------------|---|---|---|---------------------------------|
| 67 10474 | | | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED
(Type or Print) | | | | JERRY (JAROSLAV) SUCHANEK | | 2. DATE AND HOUR OF DEATH
Oct. 30, 1967 3:50 a. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | Md., 21205 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| 725 N. Collington Ave. | | | | Baltimore | | 7-03 | |
| D. STREET ADDRESS (If rural, give location) | | 725 N. Collington Ave. | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) | | |
| male | white | married | 12/13/1891 | 75 | Tailor | | |
| 10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF
WHAT COUNTRY? |
| Lebow Bros. | | | Czechoslovakia | | U.S.A. | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Joseph Suchanek | | | | Mary Hala | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| 213-10-7841 | | | | 213-10-7841 | | Marie Zeleny Suchanek, wife, above | |
| 18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN
ONSET AND DEATH | |
| ACUTE MYOCARDIAL FAILURE | | | | OCT 2 1967 | | | |
| ARTERIOSCLEROTIC C.V. | | | | 7-26-67 | | | |
| DISEASE | | | | 7-26-67 | | | |
| II | | | | DIABETES MELLITUS | | 7-26-67 | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? | |
| NONE | | NONE | | NO | | NONE | |
| 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | | 21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| NONE | | NONE | | NONE | | | |
| 21D. TIME
OF INJURY
(APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| NONE | | While At Work <input type="checkbox"/> While At Home <input type="checkbox"/> | | NONE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 24 1967 to Oct 30 1967.
that (I) (we) last saw the deceased alive on Oct 30 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| E. G. Schimunek | | | | 10-31-67 | | | |
| 23C. PHYSICIAN'S
NAME (Type) | | | | 23D. ADDRESS | | | |
| Dr. Emmanuel Schimunek | | | | 842 S. East Avenue | | | |
| 24A. BURIAL CREMATION,
REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 11/2/67 | | Bohemian National Cem. | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| NOV 3 1967 | | E. G. Schimunek | | Schimunek Funeral Home, Inc. | | 2601 E. Madison St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10475 | |
|--|---------------------|---|-----------------------------------|--|--|
| 67 10475 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Robinson, GEORGE | | 10.31.67 | | 730 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| | | A. STATE Md.
B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Johns Hopkins Hospital
33 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
3303 EIMLEY AVE. | | | |
| 5. SEX
M | 6. RACE
W | 7. <input checked="" type="checkbox"/> MARKED NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
9/6/90 | 9. AGE (in years lost birthday)
77 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Blacksmith | | 10B. KIND OF BUSINESS OR INDUSTRY
B & O R. R. | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 13. FATHER'S NAME
Frederick Robinson | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
705-03-9471 | | 17. INFORMANT ADDRESS
8569 Harris Ave., 21234
Andrew F. Whitney, step-son, | |
| 18. I 62.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Pneumonia
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Obstruction @ main bronchus
Squamous cell ca. of lung. | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
21 days
21 days
? | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-7 19 67 to 10-31 19 67 , that (I) (we) last saw the deceased alive on 10.31 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Christopher B. Merritt
M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
Christopher B. Merritt | | | | 23D. ADDRESS
Johns Hopkins Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/3/67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
Robert S. Johnson | | 25C. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane | |
| | | | | ADDRESS | |

Johns Hopkins Hospital

O

M W

3303 Elmley Ave.
2/6/20 21

Prisoner
Johns Hopkins Hospital
Prisoner call co. if need

Yes No

Christopher R. Mearns
Greenwich R. Mearns

10-31

10-31

10-31

10-31

Johns Hopkins Hospital, Johns Hopkins

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|---|---|---|---|
| BIRTH NO.
67 10476 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67 10476 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) CATHERINE F. BIGGS | | | 2. DATE AND HOUR OF DEATH
11-1-67 10:00 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
44 UNION MEMORIAL HOSPITAL
(If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1902 Hillenwood Rd. 21214
XXXXXX HARFORD ROAD | | |
| 5. SEX
FEMALE | 6. RACE
CAUCASIAN | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
10-30-80 | 9. AGE (In years last birthday)
87 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
NONE | 11. BIRTHPLACE (State or foreign country)
Baltimore MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S. |
| 13. FATHER'S NAME
ADAM WALTERS | | | 14. MOTHER'S MAIDEN NAME
SOPHIE (UNKNOWN) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-48-5050 | 17. INFORMANT
HOSPITAL ADMISSION HISTORY | | |
| 18. 430.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) DUE TO Myocardial infarction
(B) DUE TO coronary occlusion
(C) M. label | | |
| 19A. DATE OF OPERATION
2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from 10-19-67 19 67 to 11-1 19 67 , that (I) (<u>we</u>) last saw the deceased alive on November 1 19 67 and that in (<u>my</u>) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (<u>did not</u>) view the body after death. | | | | | |
| 23A. SIGNATURE
B. E. Cathey | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
11-1-67 |
| 23C. PHYSICIAN'S NAME (Type)
B. E. CATHEY | | | 23D. ADDRESS
M.D. UNION MEMORIAL HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
11/4/67 | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
B. E. Cathey | | 25C. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane | |

B. E. CATHEY
D. E. CATHEY

UNION MEMORIAL HOSPITAL
11-1-67 X

November 1 67 10-11-67

11-1-67

Yes Yes

M. Hobbs
recording - chronic
Myocardial infarction

21-11-2002 HOSPITAL ADMISSION HISTORY

20518 (UNKNOWN)

MARYLAND

U.S.

10-30-80 87

2340 HAWARD ROAD

GALETON

GALETON

ABRAHAM WALTERS
HOUSEWIFE
None
FEMALE CAUCASIAN
Wounded
Union Memorial Hospital

Butler, Emma
414180
B 34
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

| | | | | | |
|--|------------------|--|-------------------------------|--|--|
| BIRTH NO. 67 10477 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10477 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Emma J. Butler | | 2. DATE AND HOUR OF DEATH
11/1/67 1:20 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
33 THE JOHNS HOPKINS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 21205
D. STREET ADDRESS (If rural, give location)
737 N. MILTON AVENUE | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
9-26-0600 | 9. AGE (In years
lost (specify))
67 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Waitress-cook | | 10B. KIND OF BUSINESS OR INDUSTRY
Lang's | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
JOHN NOVOTNY Novotny | | 14. MOTHER'S MAIDEN NAME
MARY KASPER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
216-07-3354 HA | | 17. INFORMANT 115 Sipple Ave., 36 ADDRESS
Mrs. Mary Butler, dght-in-law | |
| 18. 420,01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>Coronary Artery</u>
DUE TO
(B) <u>Atherosclerotic Heart Disease</u>
DUE TO
(C) <u>and Arterial Embolization</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Hyperthyroidism</u> | | | | | |
| 19A. DATE OF OPERATION
10/31/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Embolus to Aortic Arterization</u> | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/31 / 19 67 to 11/1 / 19 67, that (I) (we) last saw the deceased alive on 11/1 / 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Freeman L. Wirth, Jr.</u> M.D. | | 23B. DATE SIGNED
11/1/67 | | 23C. PHYSICIAN'S NAME (Type)
<u>Freeman L. Wirth, Jr.</u> M.D. | |
| 23D. ADDRESS
<u>Johns Hopkins Hospital</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | |
| 24B. DATE
11/4/67 | | 24C. NAME of CEMETERY or CREMATORY
Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
<u>Robert E. Farber, MA</u> | | 25C. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
2600 E. Madison St. | |

1/22

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
|---|--|------------------------|--|---|--|--|--|
| | | | | Miller, Florence | | 10/31/67 11:25 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| Bolton Hill Convalescent & Nursing Ctr. | | | | Baltimore 11-03 | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| F | | W | | Widow | | 6/22/91 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years lost birthday) | |
| | | | | | | 67 | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| New York | | | | U.S. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| George Niles | | | | Annie Harvey | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | 212-18-3507 | | | |
| 18. CAUSE OF DEATH | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osseous, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | 1 week and years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | | 3/67 | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/20 1967 to 10/31 1967, that (I) (we) last saw the deceased alive on 10/31 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | | | 23B. DATE SIGNED | |
| Allen Wright | | | | | | 10/1/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS | |
| | | | | | | 2 East Red St Balto Md 21202 | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| 11-2-67 | | | | | | Johns Hopkins Univ. School of Med. Dept. of Anatomy, 709 N. Wolfe St. Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| NOV 3 1967 | | | | MORTUARY SERVICE - BCHD | | | |



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LLOYD

B

LANG

2. DATE AND HOUR PRONOUNCED DEAD

October 31, 1967

11:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)33
Johns Hopkins Hospital4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1321 Homestead Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

May 30, 1925

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

Goodwill Industry

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Lang

14. MOTHER'S MAIDEN NAME

Annie Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W. II

16. SOCIAL
SECURITY NO.

215-12-1249

17. INFORMANT

ADDRESS

Mrs. Christine Johnson 2714 Tivoly Ave. 21218

18. CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cranio-Cerebral Injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1321 Homestead St.

21D. TIME
OF INJURY
(APPROX.)

10/29/67

UNK

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Fell during an epileptic seizure

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/31/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

11-3-67

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 3 1967

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Marshall W. Jones, Jr.

1735 Harford Avenue

43

May 20, 1955

Generated

12.4.4

Goodell, I. Henry, Baltimore, Maryland

Track Delivery

Smith Road

James Lane

11-3-57 Mrs. Constance Johnson 1114 Tilden Ave.

1.9.11

Yes

11-3-57 Baltimore National Cemetery Baltimore, Maryland
Goodell, I. Henry, Baltimore, Maryland

11-3-57

Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released on Approval for the Medical Examiners Office by: Dr. Contastablas

| | | | | | |
|--|---|--|---|--|---|
| BIRTH NO. 67 10480 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10480 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Eunice (Bligen, Reid) Jackson | | 2. DATE AND HOUR OF DEATH
11/1/67 8 ³⁵ A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
33 The Johns Hopkins Hospital | | D. STREET ADDRESS (If rural, give location)
1223 E. Biddle St. | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
separated | 8. DATE OF BIRTH
4-8-22 | 9. AGE (In years lost birthday)
45 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
housewife | | 11. BIRTHPLACE (State or foreign country)
Charleston, S. C. | |
| 13. FATHER'S NAME
Frank Reines | | 14. MOTHER'S MAIDEN NAME
Rosa Crawford | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mrs. Rosa Mack 1223 E. Biddle St. 21202 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, given rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
(A) Hepatic failure + acidosis
(B) Laennec's cirrhosis
(C) chronic alcoholism | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No. | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/31/67 19 to 11/1/67 19 67, that (I) (we) last saw the deceased alive on 11/1/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Elizabeth H. Jansson | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
11/1/67 | |
| 23C. PHYSICIAN'S NAME (Type)
Elizabeth H. Jansson | | 23D. ADDRESS
Box 214 Johns Hopkins Hospital, Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
11-4-67 | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
1735 Harford Ave. Marshall W. Jones, Jr. 21213 | |

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10/10/10

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1
L-200

67 10481 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 10481

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALBERT LEAKS

2. DATE AND HOUR PRONOUNCED DEAD

October 29, 1967 1:50 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2115 Homewood Ave.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

10-10-1934

9. AGE (in years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life (even if retired))

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James M. Leaks

14. MOTHER'S MAIDEN NAME

Pauline Leaks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Will I Home North Carolina

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 30, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

11-2-67

23C. NAME OF CEMETERY or CREMATORY

Rose Hill Cmt

23D. LOCATION

(City, town, or county) (State)

North Carolina

24A. DATE REC'D BY HEALTH DEPT.

NOV 3 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Will I Home North Carolina

ADDRESS

WITNESS

NOTARY PUBLIC

FOR THE STATE OF NEW YORK

IN SENATE

11-20

11-20

11-20

11-20

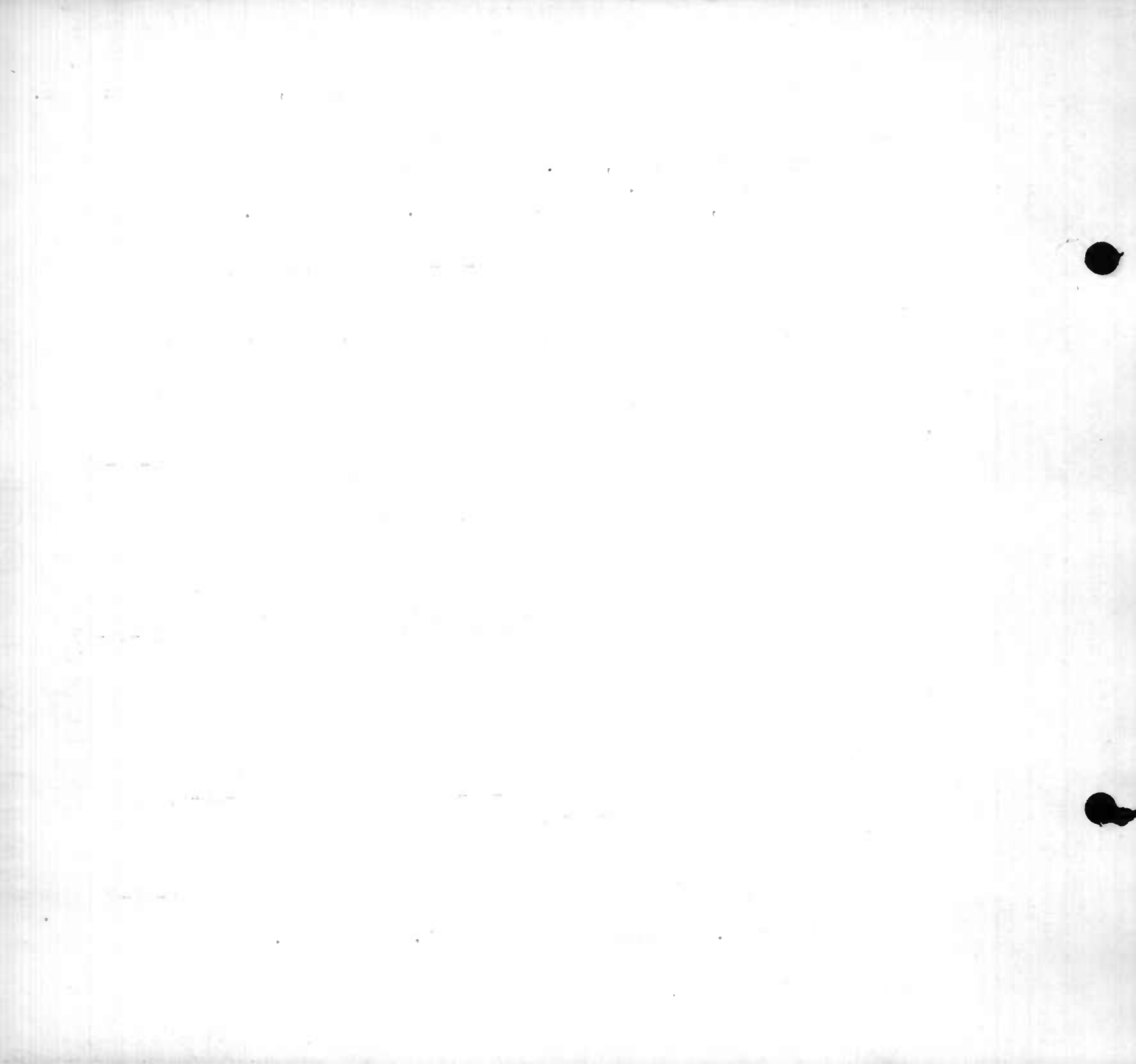
11-20

11-20

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10482 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 10482 | | | |
|---|------------------|--|-----------------------------|---|--|---|---|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Addie Hammond | | | | 2. DATE AND HOUR OF DEATH
October 28, 1967 9:20 a.m. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
39 Provident Hospital, Inc.
1514 Division St.
Baltimore, Maryland 21217 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | 15-04 | | | |
| D. STREET ADDRESS (If rural, give location)
2137 N. Smallwood St. | | | | | | | | | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
5-29-96 | 9. AGE (In years
last birthday)
70 | 10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)
Housewife | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF
WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
James Junstall | | | | 14. MOTHER'S MAIDEN NAME
Bettie Lewis | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL
SECURITY NO.
24-12-9088 | | 17. INFORMANT
Isaiah Hammond | | ADDRESS
Same | | | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last. | | | | (A) Diabetic Acidosis
DUE TO
Diabetes Mellitus
(B) DUE TO
(C) DUE TO | | | | INTERVAL BETWEEN
ONSET AND DEATH
10-26-67 | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | | | Cerebral Arteriosclerosis
Cerebral Thrombosis | | | | 10-20-67 | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | | 21C. WHERE DID
INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME
OF INJURY
(APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At <input type="checkbox"/> Not While
Work At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-20-67 19 to 10-28-67 19
that (I) (we) last saw the deceased alive on 10-28-67 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Gilbert L. Banfield M.D. | | | | 23B. DATE SIGNED
10-28-67 | | | | | | | |
| 23C. PHYSICIAN'S
NAME (Type)
Gilbert L. Banfield M.D. | | | | 23D. ADDRESS
722 N. Fulton Ave. | | | | | | | |
| 24A. BURIAL CREMATION,
REMOVAL (Specify)
Burial | | 24B. DATE
11-2-67 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cemetery | | 24D. LOCATION
(City, town, or county) (State)
Baltimore Md. | | | | | |
| 25A. DATE RECD. BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Fairbank | | 25C. FUNERAL DIRECTOR
Arlington Phillips | | 25D. ADDRESS
1727 Morris St. | | | | | |



T-460

67 10483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 10483

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HERBERT TOLER

2. DATE AND HOUR OF DEATH

10-30-67

1:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2812 BELMONT AVENUE

#21216

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

6-30-12

9. AGE (In years
last birthday)

55

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance Man

10B. KIND OF BUSINESS OR INDUSTRY

Plumber Helper

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA (Smithfield)

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

PERRY TOLER

14. MOTHER'S MAIDEN NAME

IDA EVERETT

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

241-12-5669

17. INFORMANT

RECORDS-BCH-4940 EASTERN AVENUE#

ADDRESS
BALTIMORE, MD.18. 141.94-002.1
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 10 19 67 to Oct 30 19 67,
that (I) (we) last saw the deceased alive on Oct 29 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

DR. MARY ANN SULLIVAN

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

10/30/67

23D. ADDRESS

M.D.

BCH-4940 EASTERN AVENUE, BALTIMORE, MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/4/67

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION

Arbutus Balto Co.

Md

25A. DATE REC'D BY HEALTH DEPT.

NOV 3 1967

25B. NAME OF REGISTRAR

Robert E. Farkner

25C. FUNERAL DIRECTOR

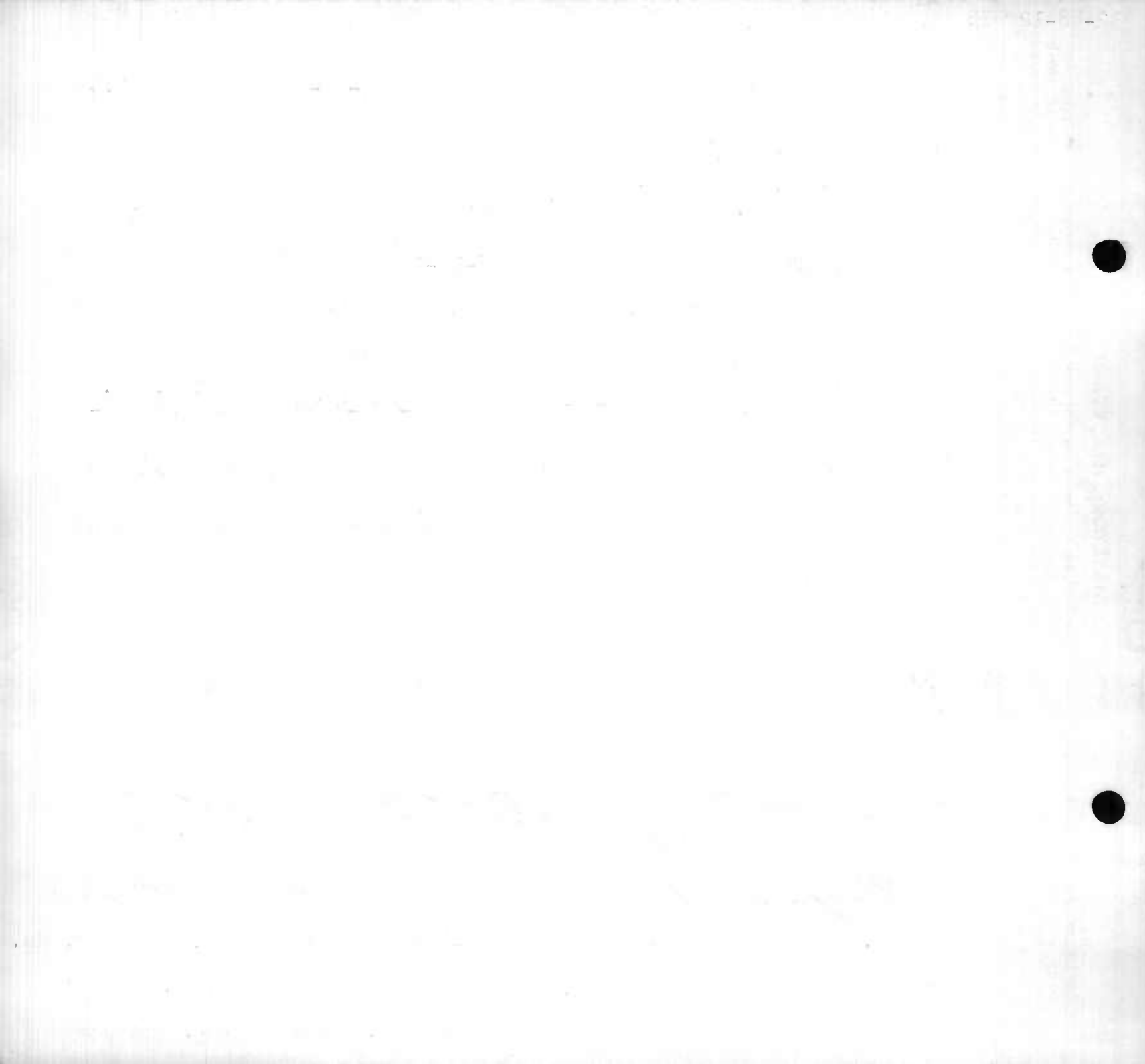
Herbert E. Nutter

ADDRESS

3035 W. North Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10484 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10484 | |
|--|--------------------|---|------------------------------------|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Sylvester Augustus Harrington | | October 27, 1967 5 ⁰⁰ P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE
Maryland | | B. COUNTY | |
| 00 2415 Callow Ave | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | 13-01 | |
| | | | | D. STREET ADDRESS (If rural, give location)
2415 Callow Ave | | | |
| 5. SEX
Male | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
April 18, 1906 | 9. AGE (In years last birthday)
61 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Minister & Engineer | | 10B. KIND OF BUSINESS OR INDUSTRY
Religion | | 11. BIRTHPLACE (State or foreign country)
Opelousa, La | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
Elmo Harrington | | | | 14. MOTHER'S MAIDEN NAME
Victoria Linton | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-24-5514 | | 17. INFORMANT ADDRESS
Mrs. Mary E. Harrington 2415 Callow Ave | | | |
| 18. 153, 11 CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
CANCER OF GALL BLADDER | | | | 14y | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
1-2-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
CANCER | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-17-1955 to 10-27-1968, that (I) (we) last saw the deceased alive on 10-27-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Maurice L. Adams | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
10-30-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Maurice L. Adams | | | | 23D. ADDRESS
238 N. Carey Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
10/31/67 | | 24C. NAME of CEMETERY or CREMATORY
Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Arbutus Balto. Co. Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 8 1967 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Herbert E. Nutter | | ADDRESS
3035 W. North Ave | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 10485</u> | |
|--|-------------------------|---|-----------------------------------|--|---|
| BIRTH NO. <u>67 10485</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>THOMAS J. MASON</u> | | 2. DATE AND HOUR OF DEATH
<u>10-28-67</u> <u>1:30 A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>90 LINCOLN MEMORIAL NURSING HOME</u> | | A. STATE <u>MARYLAND</u>
B. COUNTY <u>BALTIMORE</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>18-02</u>
D. STREET ADDRESS (If rural, give location) <u>27 N. CAREY STREET</u> | | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>NEGRO</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
<u>6-3-90</u> | 9. AGE (In years last birthday)
<u>77</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>PAPER HANGER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Self Employed</u> | | 11. BIRTHPLACE (State or foreign country)
<u>BALTIMORE MD</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | | 13. FATHER'S NAME
<u>THOMAS MASON</u> | | 14. MOTHER'S MAIDEN NAME
<u>SARAH</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>218-32-5372</u> | | 17. INFORMANT
<u>Mrs Mary Perry</u> ADDRESS <u>1817 Maryland Ave</u> | |
| 18. <u>260X1</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <u>CEREBRAL THROMBOSIS</u> DUE TO
(B) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO
(C) <u>DIABETES MELLITUS</u> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8-18-1967</u> to <u>10-28-1967</u> , that (I) (we) last saw the deceased alive on <u>10-28-1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>[Signature]</u> | | | | 23B. DATE SIGNED
<u>10/28/67</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>[Signature]</u> | | | | 23D. ADDRESS
<u>2519 KENNEDY AVE BALTIMORE MD</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>11/2/67</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>MOUNT CALVARY</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>ANNA ARAUDIE CO MD</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>NOV 3 1967</u> | | | |
| 25B. NAME OF REGISTRAR
<u>[Signature]</u> | | 25C. FUNERAL DIRECTOR
<u>HERBERT E. NATTER</u> ADDRESS <u>3035 W. NORTH AVE</u> | | | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|--|--|--|----------------------------------|--|
| 67 10486 | | 67 10486 | | E.S.T. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | WILLIAMS, BENJAMIN F | | OCTOBER 29, 1967 2:30 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| 40 ST AGNES HOSPITAL | | MARYLAND | | 21228 | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location) | | 53-00 | |
| | | 2 MILBERT COURT | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| MALE | NEGRO | MARRIED | 08-09-11 | 56 | PORTER |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| | | STEWART & CO. | MARYLAND (CATONSVILLE) | U.S.A. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| AMOS WILLIAMS | | | MAMMIE HENLEY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| WW-II | | 213-03-2106 | ST AGNES HOSPITAL'S RECORD | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Cerebrovascular accident. | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 0 | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from OCTOBER 27 1967 to OCTOBER 29 1967, that (X) (we) last saw the deceased alive on OCTOBER 29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| J. Korbuly | | | | 10-29-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| J. KORBULY | | M.D. ST. AGNES HOSPITAL - | | WILKENS & CATON | |
| | | | | BALTO., MD., 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 11/1/67 | Baltimore National Cemetery | Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| NOV 3 1967 | Robert E. Farley, M.D. | Herbert E. Nutter 3035 W. North Ave | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

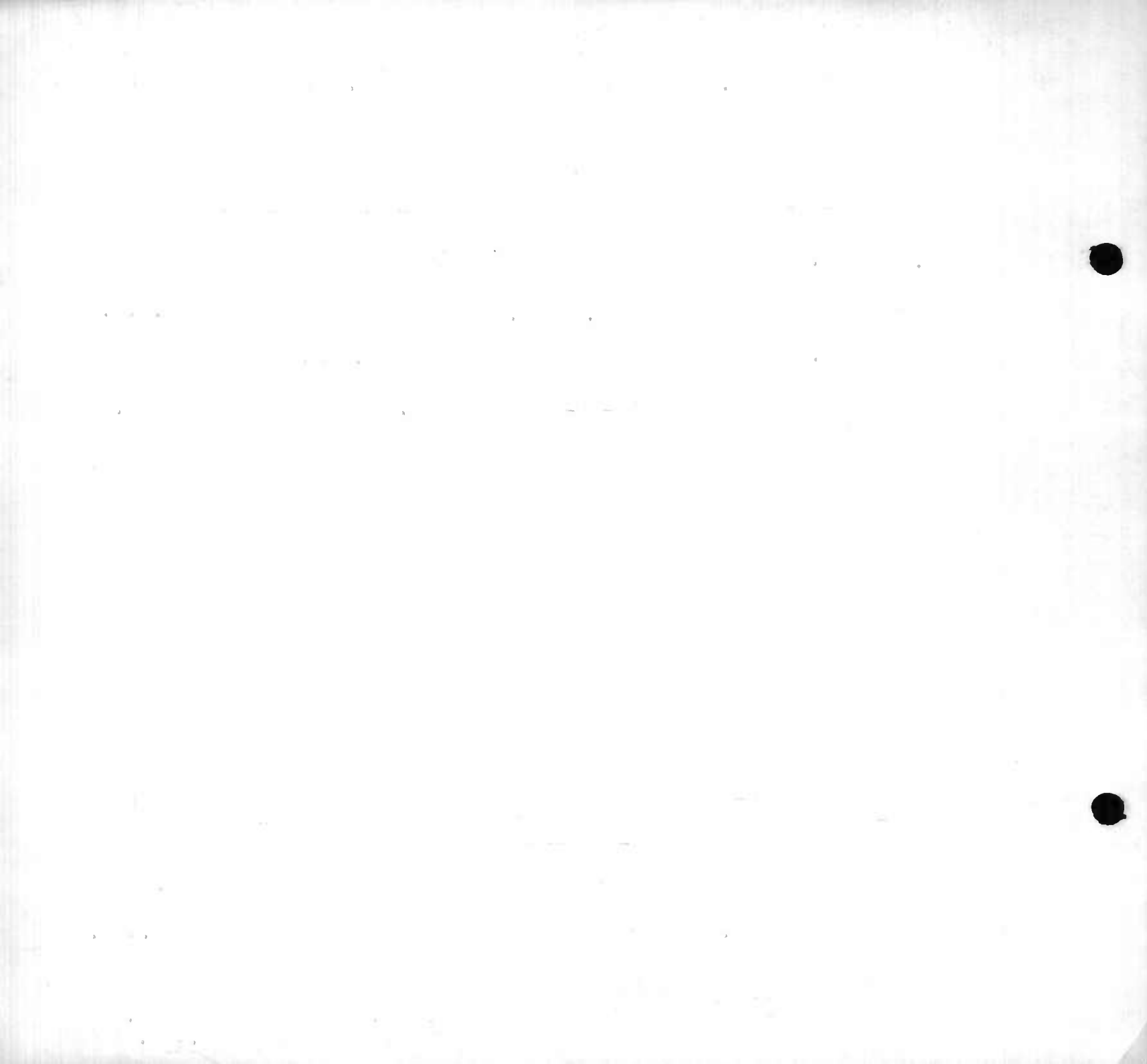
| BIRTH NO. 67 10487 | | | |
|---|---------------|--|--|
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| Eleanor F. Pipitone | | Nov. 1, 1967 9:15 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION

90 House-In-Pines Belvedere | | A. STATE
Maryland
B. COUNTY
Baltimore | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | |
| Baltimore | | 27-17 House-In-Pines - Belvedere | |
| 5. SEX
F. | 6. RACE
W. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
1/4/1871 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dispenser | | 10B. KIND OF BUSINESS OR INDUSTRY
Linen | 9. AGE (In years last birthday)
96 |
| 11. BIRTHPLACE (State or foreign country)
Capeville, Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William F. Fitchett | | 14. MOTHER'S MAIDEN NAME
Georgia W. Fitchett | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-32-1496 | |
| 17. INFORMANT
John M. Myers | | ADDRESS
1808 Ruxton Road
Baltimore, Md. | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) Arteriosclerotic cardio-vascular disease
DUE TO

(B) _____
DUE TO

(C) _____ |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | 15 yrs. |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 19, 19 67 to November 1, 19 67, that (I) (we) last saw the deceased alive on October 25, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>Lloyd E. Saylor</i> M.D. | | | 23B. DATE SIGNED
Nov. 2, 1967 |
| 23C. PHYSICIAN'S NAME (Type)
Lloyd E. Saylor M.D. | | | 23D. ADDRESS
3902 Greenmount Ave, Balto., Md. |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11/3/67 | |
| 24C. NAME OF CEMETERY or CREMATORY
Lorraine Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Woodlawn Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
<i>Robert E. Jenkins</i> | |
| 25C. FUNERAL DIRECTOR
Henry W. Jenkins & Sons Co. | | ADDRESS
4905 York Road, Balto., Md. 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10488 | | | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 67-10488 | |
|---|-------------------------|--|--|--|--|--|---|
| 1. NAME OF DECEASED
(Type or Print) <i>John H. Litaker</i> | | | | 2. DATE AND HOUR OF DEATH
<i>10/29/1967 12:35 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>90 George Washington Nursing Home</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>25-06</i>
D. STREET ADDRESS (If rural, give location) <i>3308 Tate Street</i> | | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>Negro</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>7/13/1880</i> | | 9. AGE (In years last birthday)
<i>87</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Laboree</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>North Carolina</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> |
| 13. FATHER'S NAME
<i>John Litaker</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Angeline</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Unknown</i> | | | 16. SOCIAL SECURITY NO.
<i>217-01-38114</i> | | 17. INFORMANT
<i>Chart # 746</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <i>Acute Coronary Occlusion</i>
DUE TO
(B) <i>Arterio-sclerotic Heart Disease</i>
DUE TO
(C) <i>Chronic Brain Syndrome</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 day</i>
<i>Unknown</i>
<i>Unknown</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/7</i> 19 <i>65</i> to <i>10/29</i> 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>10/27</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>E.E. Holt</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>10/31/67</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>E.E. Holt</i> | | | | 23D. ADDRESS
M.D. <i>3715 Liberty Hts. Ave.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>11/2/67</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Mt Calvary Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Anne Arundel Cty., Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
<i>Robert E. Finkbeiner</i> | | 25C. FUNERAL DIRECTOR
<i>Wm C March</i> | | | |
| | | | | ADDRESS
<i>928 E. North Ave.</i> | | | |

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Labore

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F. E. Holt

212 West 14th Ave

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67 10489

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

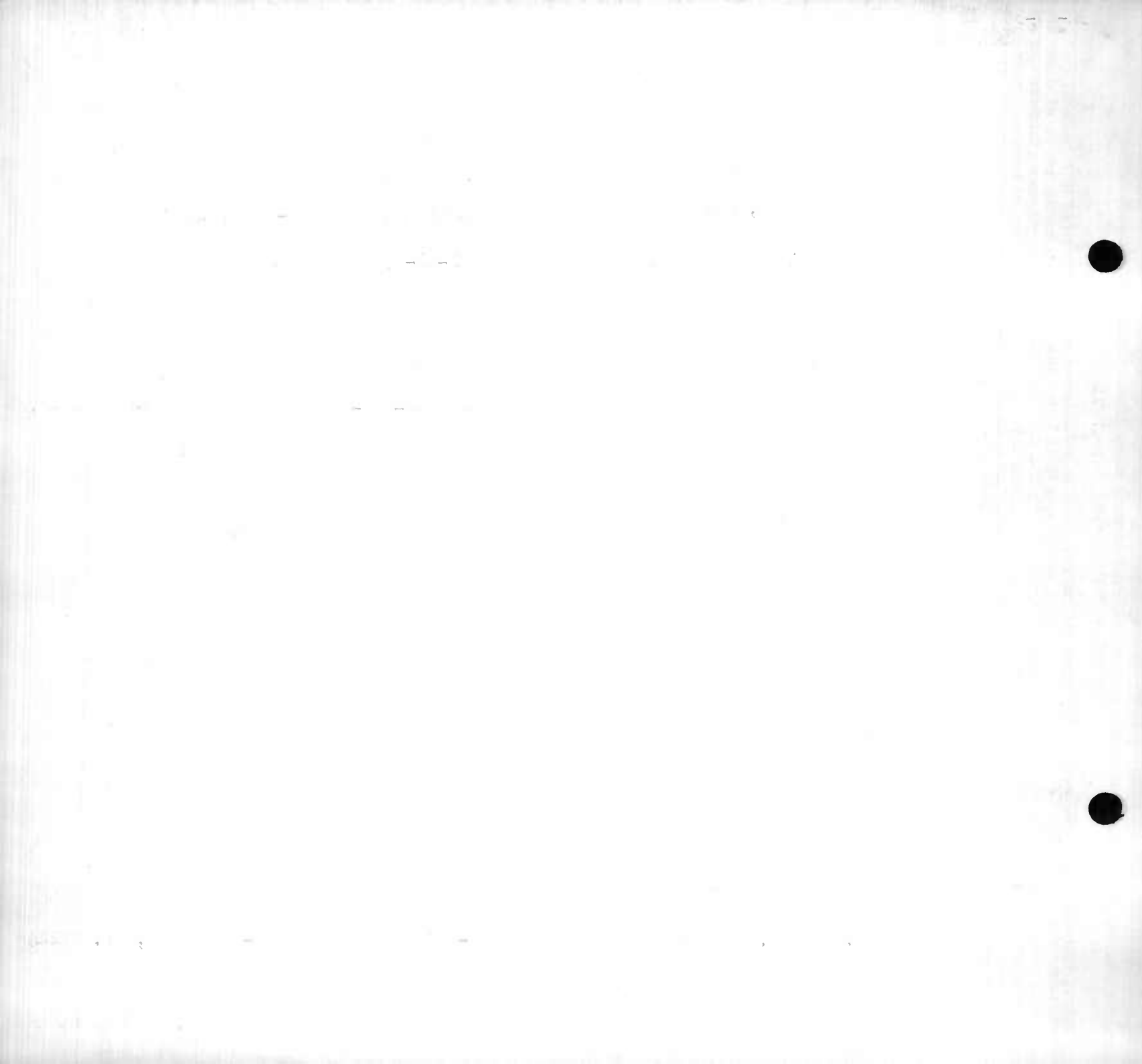
Registered No. 67 10489

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

| | | | |
|--|-----------------------------|---|--|
| BIRTH NO. 67 10489 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) Louise Green | | 2. DATE AND HOUR OF DEATH
Oct. 31 1967 11:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
3403 ROYCE AVENUE- 21215 | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
11-11-19 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
47 |
| 13. FATHER'S NAME
HENRY STRICKLAND | | 14. MOTHER'S MAIDEN NAME
DAISY TUGGLE | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
RECORDS-BCH-4940 EASTERN AVENUE-BALTIMORE, MD |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Septicemia | | INTERVAL BETWEEN ONSET AND DEATH
4 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Cutaneous-enteric fistula 2 months
(C) Adenocarcinoma - Colon 6 months | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
1 | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 28 19 67 to Oct. 31 19 67 , that (I) (we) last saw the deceased alive on Oct. 31 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Ross T. Krueger | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | 23B. DATE SIGNED
Oct. 31, 1967 |
| 23C. PHYSICIAN'S NAME (Type)
DR. ROSS T. KRUEGER | | 23D. ADDRESS
BCH-4940 EASTERN AVENUE-BALTIMORE, MD. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
11/4/67 | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cem. | 24D. LOCATION (City, town, or county) (State)
Anne Arundel City, MD. |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | 25C. FUNERAL DIRECTOR
WM MARLH 928 E North Ave. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 10480 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 1007 87 10480 | |
|--|---------|--|-----------------------------------|---|--|--|------------------------------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Dunbar, Lonnie B. (Loney) | | | | 11/2/67 1:40 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 90 Bolton Hill Convalescent & Nursing Ctr. | | | | Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 1518 Aisquith Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| M | N | Married | 7/18/00 | 67 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Steel worker | | | Steel | | North Carolina | | U.S. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Richmond Dunbar | | | | Vinnette Collins | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | | | 179-10-1504 | | Connie Dunbar 1518 N. Aisquith St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| CELEBRAL THROMBOSIS | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/28/67 to 11/2/67 that (I) (we) last saw the deceased alive on 11/2/67 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Hollis Seunarine M.D. | | | | 11/2/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Hollis Seunarine | | | | 930 WHITELOCK ST. BALTO. MD | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 11-6-67 | | Arbutus Memorial Park | | Arbutus (Balto. Co.) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| NOV 3 1967 | | R. E. Taylor | | Marshall W. Jones, Jr. | | 1735 Harford Ave. | |

Case over - indicated

2/2

11/2/07

2/22/07

11/2/07

[Signature]

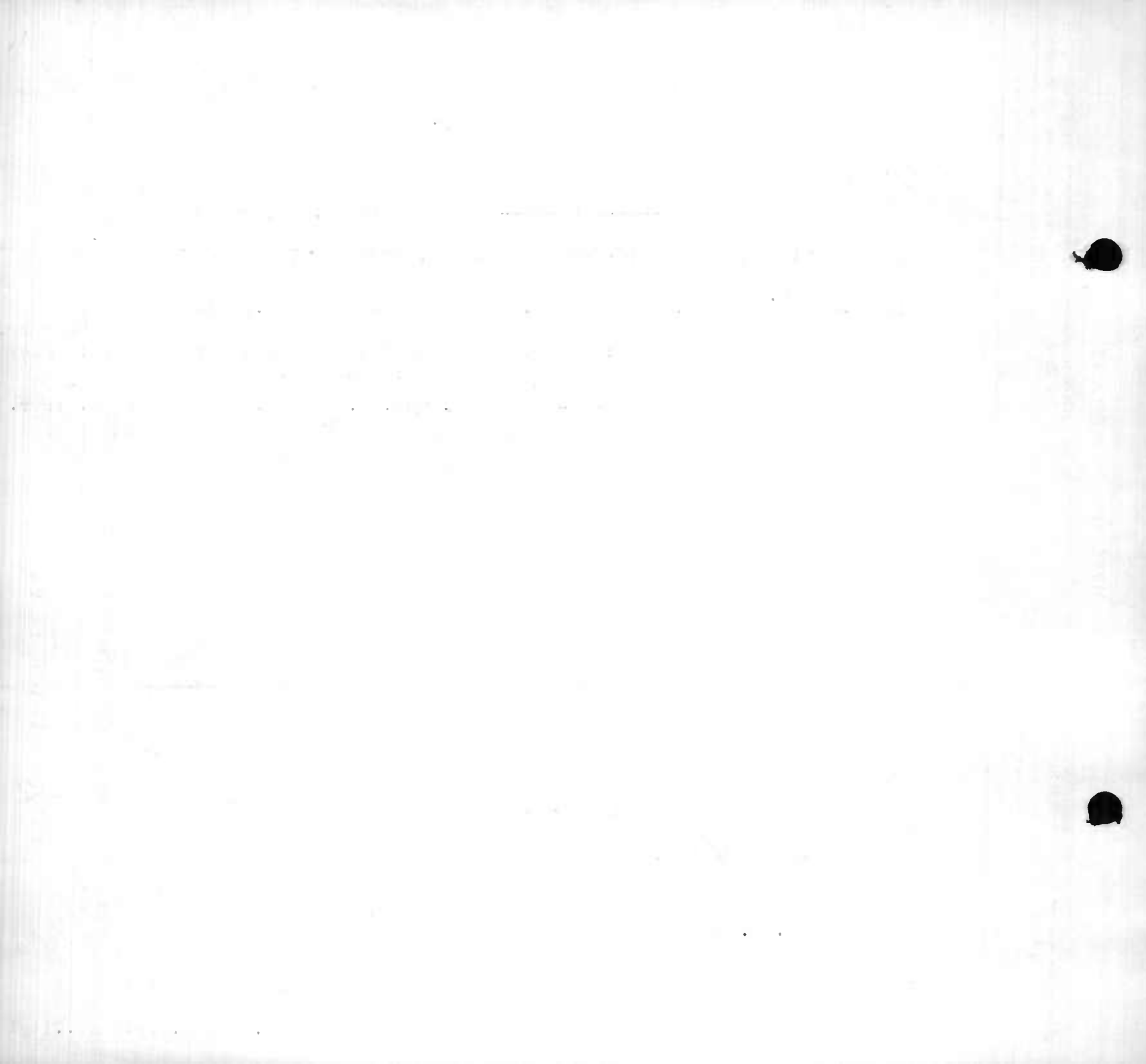
11/2/07

Case over - indicated

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|--|--|--|--|--|--|--|
| BIRTH NO. 67 10491 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 67 10491 | | | | |
| 1. NAME OF DECEASED
(Type or Print) BLANCHE GARDNER POWELL | | | | | 2. DATE AND HOUR OF DEATH
Nov 1, 1967 4⁰⁰ A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 27-13 | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
5015 Falls Road Terrace | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | |
| D. STREET ADDRESS (If rural, give location)
RESIDENCE ----- 5015 Falls Road Terrace | | | | | | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
May 11, 1880 | 9. AGE (In years last birthday)
87 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Exec. Retired - Secty | | | 10B. KIND OF BUSINESS OR INDUSTRY
Md. Nurses Assn. | | 11. BIRTHPLACE (State or foreign country)
Near: Chillicothe, Ross Co., Ohio | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME
Wilson Gardner (Born: Porter, Ohio) | | | 14. MOTHER'S MAIDEN NAME
Emeline Charlotte Brown (Born: Ohio) Harmer, | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
212-01-8209 | | 17. INFORMANT: Daughter, ADDRESS City - 10 | | | | |
| | | | Mrs. Geo. H. Dowell, 5015 Falls Rd. Terr. | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerosis | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 31, 1955 to Nov 1, 1967 that (I) (we) last saw the deceased alive on Oct 31, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Wm. G. Helfrich M.D. | | | | | 23B. DATE SIGNED
Nov 1-67 | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Wm. G. Helfrich M.D. | | | | | 23D. ADDRESS
5006 Roland Ave. Baltimore | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | 24B. DATE
11/4/67 | | 24C. NAME of CEMETERY or CREMATORY
Bluemont Cemetery | | 24D. LOCATION (City, town, or county) (State)
Grafton; West Virginia | | |
| 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | | 25B. NAME OF REGISTRAR
Robert E. Farley | | | 25C. FUNERAL DIRECTOR ADDRESS
STEWART & MOWEN CO. 108 W. North Av. Cityl | | | |



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **JOHN SHORTER** 2. DATE AND HOUR PRONOUNCED DEAD **November 1, 1967 8:05 P.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

529 N. Carrollton Avenue

A. STATE **Maryland** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

529 N. Carrollton Avenue

5. SEX **Male** 6. RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **WIDOWED** 8. DATE OF BIRTH **July 9-1907** 9. AGE (In years last birthday) **60** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **CHAUFFEUR** 10B. KIND OF BUSINESS OR INDUSTRY **Whole Fish Co.** 11. BIRTHPLACE (State or foreign country) **BALTO MD** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Nicodemus SHORTER** 14. MOTHER'S MAIDEN NAME **ANNIE BAILEY**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **NO** 16. SOCIAL SECURITY NO. **219-01-4347** 17. INFORMANT **DELORES SHORTER** ADDRESS **1734 Division St**

18. **420101** CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) **Arteriosclerotic heart disease** DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fatty metamorphosis of liver

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Springate, M.D.** EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **November 2, 1967**

23A. BURIAL CREMATION, REMOVAL (specify) **Burial** 23B. DATE **11/2/67** 23C. NAME OF CEMETERY OR CREMATORY **MT AUBURN** 23D. LOCATION (City, town, or county) (State) **Baltimore**

24A. DATE REC'D BY HEALTH DEPT. **NOV 3 1967** 24B. NAME OF REGISTRAR **Robert E. Farkas** 24C. FUNERAL DIRECTOR **Thomas A. Hayes** ADDRESS **638 N. Gilmor St**

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 06-01-2001 BY 60321

1. The first of the three main points of the report is that the government has failed to provide adequate funding for the education system. This has led to a decline in the quality of education and a loss of confidence in the government.

2. The second point is that the government has failed to implement effective policies to address the economic challenges facing the country. This has resulted in high unemployment and a decline in the standard of living.



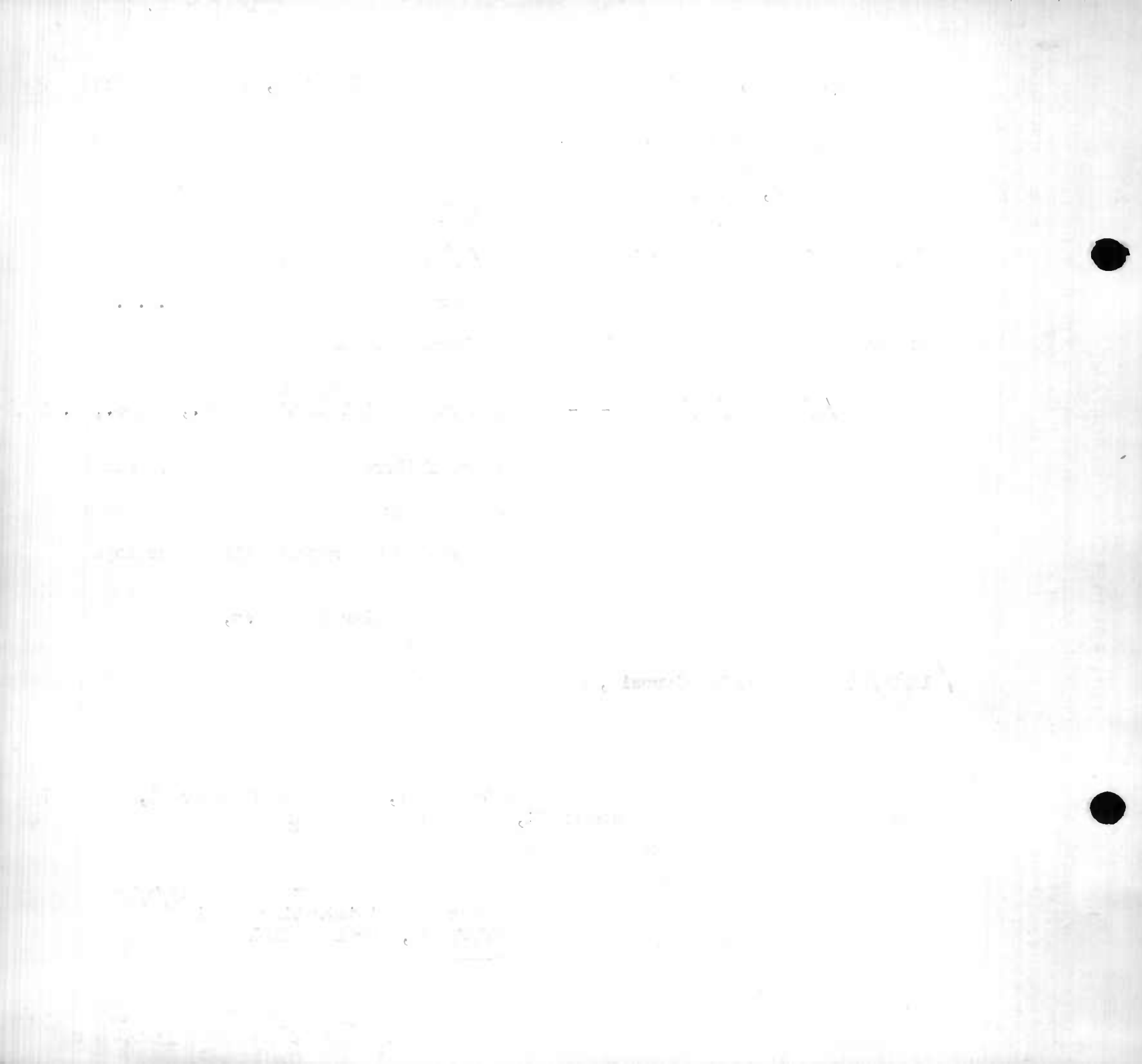
During the period of the report, the government has failed to provide adequate funding for the education system.

The first of the three main points of the report is that the government has failed to provide adequate funding for the education system.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|--|---|--|--|--|
| 67 10493 | | 67 10493 | | 67 10493 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | (12 or K) MARKS, Samuel (NMI) | | October 31, 1967 9:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address) | | A. STATE B. COUNTY | | | |
| Veterans Administration Hospital
3900 Loch Raven Blvd
Baltimore, Maryland 21218 | | Maryland | | | |
| 27 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| 27 | | Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | 1454 Reynolds Street | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | |
| Male | | White | | Married | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Unknown Paper hanger | | Unknown | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Max Marks | | Sarah ? Horwitz | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes 4/7/17 to 9/19/19 | | 212-34-5374 | | Records Veterans Administration Hosp., Balto., Md. 21218 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | 19. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| I | | (A) Renal failure | | 72 hours | |
| DUE TO | | Hypotension | | 72 hours | |
| II | | (B) Arteriolar nephrosclerosis | | 14 days | |
| DUE TO | | Cerebrovascular occlusion, right | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 10/20/67 | | Rectal polyposis, suspected | | no | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | |
| 10/20/67 | | Rectal polyposis, suspected | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from September 27, 1967 to October 31, 1967, that (X) (we) last saw the deceased alive on October 31, 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | 23A. SIGNATURE | | | |
| Edward O Hunt M.D. | | 23B. DATE SIGNED | | 11/1/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | Veterans Administration Hospital | | | |
| EDWARD O HUNT | | Baltimore, Maryland 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATOR | |
| Burial | | 11/3/67 | | Baltimore National Cemetery Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| NOV 3 1967 | | Charles E. Taylor | | Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS ISO-REV. 1/1/6S

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MILDRED COLLINS

2. DATE AND HOUR PRONOUNCED DEAD

October 30, 1967 9:45 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

506 N. Gilmore St.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

SEPERATED

8. DATE OF BIRTH

6-21-1921

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

WILMINGTON, NORTH CAROLINA U.S.A.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

JOHN GREEN

14. MOTHER'S MAIDEN NAME

MARGARET WALLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Margaret Wallace 302 N. Carey St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?
YES21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 30, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

11-4-67

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cem.

23D. LOCATION

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 3 1967

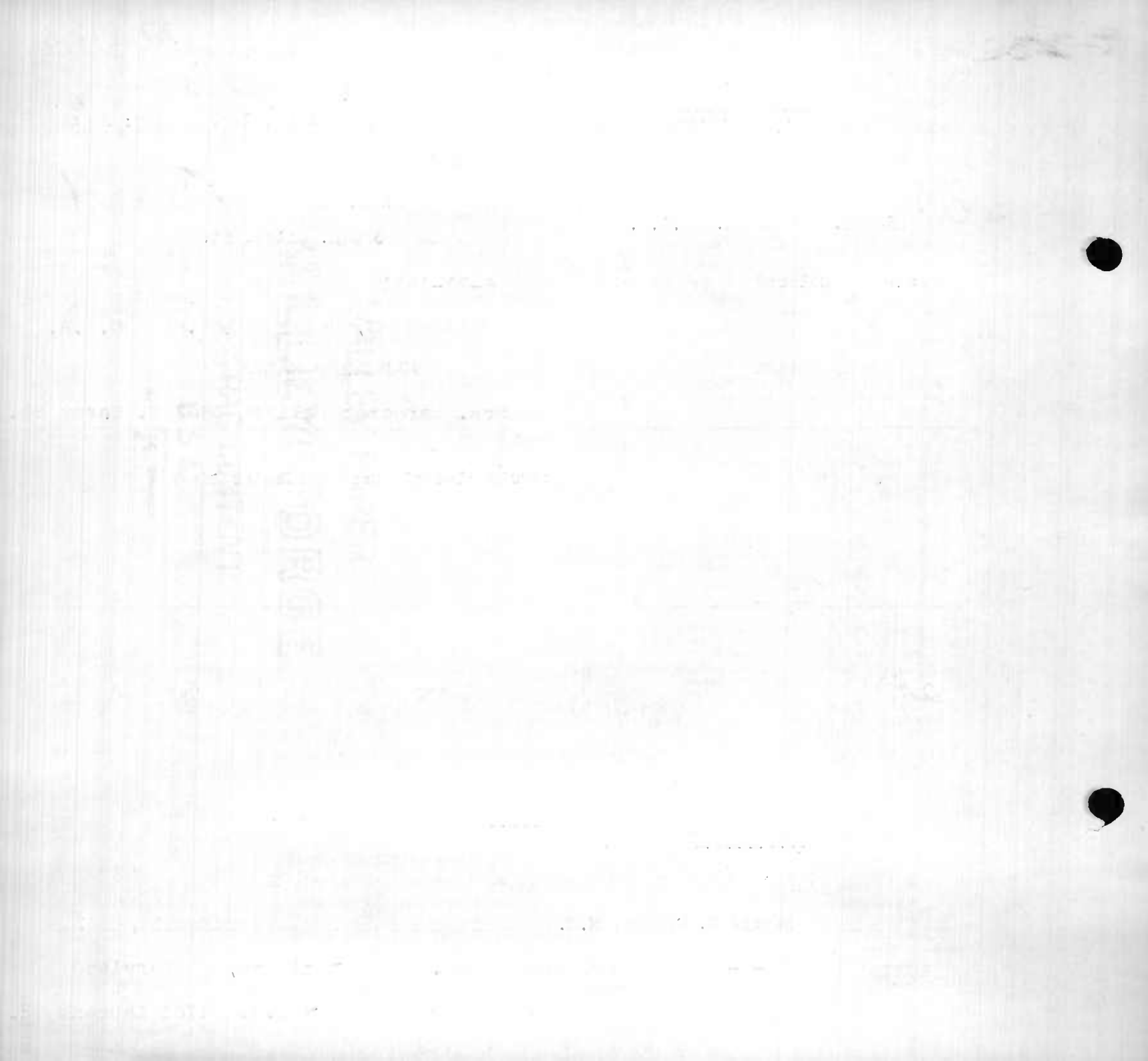
24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

MORTON & DYETT F.H. 1701 Laurens St.

ADDRESS



1
5-536

67 10496 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 10496

BIRTH NO.

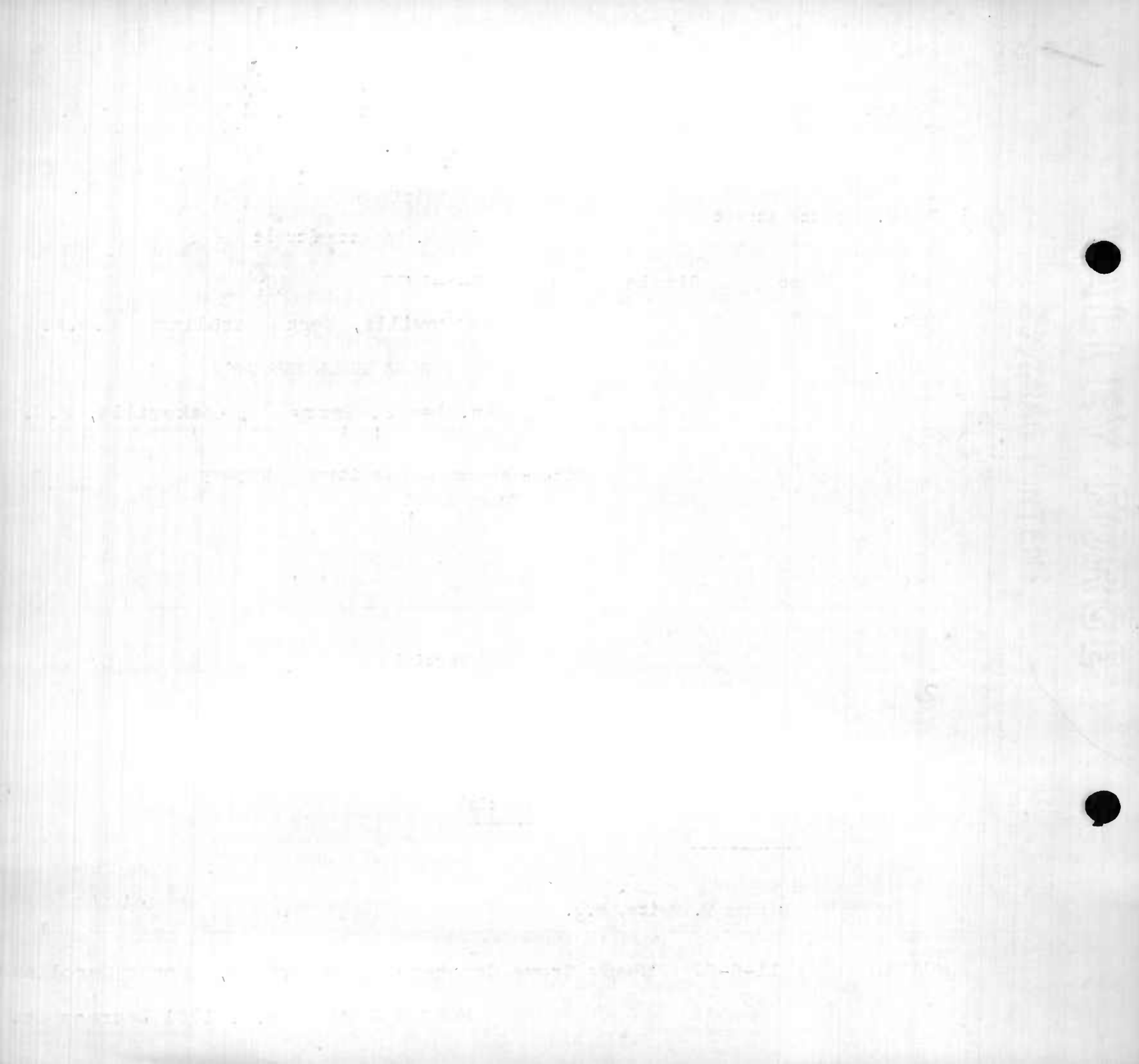
M.E. CASE NO.

| | | | |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print)
WILLIE LEE SAUNDERS | | 2. DATE AND HOUR PRONOUNCED DEAD
October 31, 1967 10:25 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
700 W. Fayette Street | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
700 W. Fayette Street | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
7-2-1927 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unk. | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
40 |
| 13. FATHER'S NAME
UNK. | | 11. BIRTHPLACE (State or foreign country)
Leaksville, North Carolina U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | 14. MOTHER'S MAIDEN NAME
ROSA BELL MURRAY | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mr. Lee S. Perry Leaksville, N.C. | |

| | | | |
|-----------------------|---|--|--|
| MEDICAL CERTIFICATION | 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Fibro-caseous and cavitary pulmonary Tuberculosis | | INTERVAL BETWEEN ONSET AND DEATH |
| | ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C) | | |
| | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Partial | | |
| | 19A. DATE OF OPERATION
2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
Yes |
| | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes |
| | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| | 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | |
| | ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Werner U. Spitz, M.D. | | DATE SIGNED
10/31/67 |

| | | | |
|---|-----------------------------|---|--|
| 23A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | 23B. DATE
11-6-67 | 23C. NAME of CEMETERY or CREMATORY
Shady Grove Cemetery | 23D. LOCATION (City, town, or county) (State)
Leaksville, North Carolina |
| 24A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | 24B. NAME OF REGISTRAR
Robert E. Farber, M.D. | 24C. FUNERAL DIRECTOR ADDRESS
MORTON & DYETT F.H. 1701 Laurens St. |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | |
|---|---|---|
| <div style="display: flex; justify-content: space-between;"> R-230 BALTIMORE CITY HEALTH DEPARTMENT Registered No. X </div> | | <div style="display: flex; justify-content: space-between;"> 67 10497 CERTIFICATE OF DEATH 67 10497 </div> |
| BIRTH NO. 67 10497
M.E. CASE NO.
1. NAME OF DECEASED (Type or Print) RAST, FREDERICK QUINTUS | | 2. DATE AND HOUR OF DEATH
<div style="display: flex; justify-content: space-between;"> OCTOBER 27, 1967 8:15 P.M. </div> |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> 27 Veterans Administration Hospital
 3900 Loch Raven Blvd
 Baltimore, Maryland 21218 </div> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY C.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Towhntown
D. STREET ADDRESS (If rural, give location)
Route 2 |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married |
| 8. DATE OF BIRTH
9/22/02 | | 9. AGE (In years lost birthday)
65 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machine Designer | | 10B. KIND OF BUSINESS OR INDUSTRY
Unknown |
| 11. BIRTHPLACE (State or foreign country)
Texas | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Felix Q. Rast | | 14. MOTHER'S MAIDEN NAME
Bessie Black |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 7/1/18 to 5/2/19 | | 16. SOCIAL SECURITY NO.
096-01-5426 |
| 17. INFORMANT
Records | | ADDRESS
Veterans Administration Hosp., Balto., Md. 21218 |
| 18. I 1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
Carcinoma of nasopharynx involving base of skull
(A) DUE TO
(B) DUE TO
(C) |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Broncho pneumonia | | INTERVAL BETWEEN ONSET AND DEATH
6Months |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED |
| 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that he (this hospital) attended the deceased from June 6, 1967 to October 27, 1967 , that he (we) last saw the deceased alive on October 27, 1967 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) not view the body after death. | | |
| 23A. SIGNATURE
R. H. Twining | | 23B. DATE SIGNED
10/31/67 |
| 23C. PHYSICIAN'S NAME (Type)
R. H. Twining | | 23D. ADDRESS
VA Hosp. Balto., Md. 21218 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
11-2-67 | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cemetery |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Wm. E. Johnson, 8521 Loch Raven Blvd. |

Y. J. C. 1000

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|---|--|---|
| 67 10498 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10498 | |
| BIRTH NO. 630 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) Albert Barrett | | | 2. DATE AND HOUR OF DEATH
11/2/67 5:12 a. m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
33 The Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1601 Eareckson Place | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
8-18-10 | 9. AGE (In years last birthday)
57 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PRESSER | | 10B. KIND OF BUSINESS OR INDUSTRY
VALMA-CLEANERS | | 11. BIRTHPLACE (State or foreign country)
N.C. | |
| 13. FATHER'S NAME
Albert Barrett | | | 14. MOTHER'S MAIDEN NAME
Emma PATON | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
083-163540 | | 17. INFORMANT ADDRESS
CILPHIA MOORE 1601 EARECKSON Pl. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cardiac standstill
DUE TO
systemic changes assoc. w/ peritonitis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
perforated duodenal ulcer | | | INTERVAL BETWEEN ONSET AND DEATH
immed.
> 1 day
> 1 day | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Carcinoma of floor of mouth Emetastasis | | | | | |
| 19A. DATE OF OPERATION
10/20/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
perforated duodenal ulcer | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
None | | 21C. WHERE DID INJURY OCCUR?
None | |
| 21D. TIME OF INJURY (APPROX.)
None | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> 0 Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
None | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 28 19 67 to Nov. 2 19 67 , that (I) (we) last saw the deceased alive on Nov. 2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Bertram Loring, MD | | | | 23B. DATE SIGNED
11-2-67 | |
| 23C. PHYSICIAN'S NAME (Type)
Bertram Loring | | | | 23D. ADDRESS
Johns Hopkins Hospital, Balto., Md. | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
11-6-67 | | 24C. NAME OF CEMETERY or CREMATORY
MT AUBURN | |
| 24D. LOCATION
BALTIMORE Md. | | 25A. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Jackson, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
JOSEPH KNIGHT 1639 N. BROADWAY | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|--|--|--|--|--|
| 67 10499 | | 67 10499 | | 67 10499 | |
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. M.E. CASE NO. </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> 1. NAME OF DECEASED
(Type or Print) 2. DATE AND HOUR OF DEATH </div> | | | <div style="display: flex; justify-content: space-between;"> 10/31/67 15:15A M. </div> | | |
| <div style="display: flex; justify-content: space-between;"> 3. PLACE OF DEATH IN BALTIMORE, MARYLAND 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) </div> | | | <div style="display: flex; justify-content: space-between;"> A. STATE B. COUNTY </div> | | |
| <div style="display: flex; justify-content: space-between;"> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) </div> | | | <div style="display: flex; justify-content: space-between;"> Maryland Baltimore </div> | | |
| <div style="display: flex; justify-content: space-between;"> 5. SEX 6. RACE </div> | | | <div style="display: flex; justify-content: space-between;"> 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) 8. DATE OF BIRTH </div> | | |
| <div style="display: flex; justify-content: space-between;"> Male Negro </div> | | | <div style="display: flex; justify-content: space-between;"> Widowed 1/15/07 </div> | | |
| <div style="display: flex; justify-content: space-between;"> 9. AGE (In years
last birthday) 10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) </div> | | | <div style="display: flex; justify-content: space-between;"> 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF
WHAT COUNTRY? </div> | | |
| <div style="display: flex; justify-content: space-between;"> 33 Longshoreman </div> | | | <div style="display: flex; justify-content: space-between;"> 60 Voc. </div> | | |
| <div style="display: flex; justify-content: space-between;"> 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME </div> | | | <div style="display: flex; justify-content: space-between;"> 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. </div> | | |
| <div style="display: flex; justify-content: space-between;"> Charlie Wiggins Lena Boone </div> | | | <div style="display: flex; justify-content: space-between;"> 17. INFORMANT ADDRESS </div> | | |
| <div style="display: flex; justify-content: space-between;"> no 212-04-3906A </div> | | | <div style="display: flex; justify-content: space-between;"> Charles J. Wiggins 1125 Hamlen Ave </div> | | |
| <div style="display: flex; justify-content: space-between;"> 18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH CAUSE OF DEATH </div> | | | <div style="display: flex; justify-content: space-between;"> 19. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED </div> | | |
| <div style="display: flex; justify-content: space-between;"> 162.141002.2 Interval between onset and death </div> | | | <div style="display: flex; justify-content: space-between;"> 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? </div> | | |
| <div style="display: flex; justify-content: space-between;"> (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) (A) Carcinoma of lung, O.O.C.A. </div> | | | <div style="display: flex; justify-content: space-between;"> 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) </div> | | |
| <div style="display: flex; justify-content: space-between;"> ANTECEDENT CAUSES 21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location) </div> | | | <div style="display: flex; justify-content: space-between;"> 21D. TIME
OF INJURY
(APPROX.) 21E. INJURY OCCURRED </div> | | |
| <div style="display: flex; justify-content: space-between;"> DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last. 21F. HOW DID INJURY OCCUR? </div> | | | <div style="display: flex; justify-content: space-between;"> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> </div> | | |
| <div style="display: flex; justify-content: space-between;"> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> Palm Healed </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> 22. I certify that (I) (this hospital) attended the deceased from 10/11 to 10/31, 1967, and that (I) (we) lost saw the deceased alive on 10/30, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> 23A. SIGNATURE 23B. DATE SIGNED </div> | | | | <div style="display: flex; justify-content: space-between;"> 23C. PHYSICIAN'S
NAME (Type) 23D. ADDRESS </div> | |
| <div style="display: flex; justify-content: space-between;"> Henry R. Black 11/4/1967 </div> | | | | <div style="display: flex; justify-content: space-between;"> Johns Hopkins Hosp. Baltimore, Md. </div> | |
| <div style="display: flex; justify-content: space-between;"> 24A. BURIAL CREMATION,
REMOVAL (Specify) 24B. DATE </div> | | | | <div style="display: flex; justify-content: space-between;"> 24C. NAME OF CEMETERY or CREMATORY 24D. LOCATION (City, town, or county) (State) </div> | |
| <div style="display: flex; justify-content: space-between;"> Burial 11/4/1967 </div> | | | | <div style="display: flex; justify-content: space-between;"> Mt. Auburn Cem. Balto. Md. </div> | |
| <div style="display: flex; justify-content: space-between;"> 25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR </div> | | <div style="display: flex; justify-content: space-between;"> 25C. FUNERAL DIRECTOR ADDRESS </div> | | | |
| <div style="display: flex; justify-content: space-between;"> NOV 3 1967 Robert E. Taylor, M.D. </div> | | <div style="display: flex; justify-content: space-between;"> Williams Funeral Home 319 N. Snowden St. </div> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|--|---|--|--|
| BIRTH NO. 67 10500 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 10500 | |
| M.E. CASE NO. | | | DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Louis Joseph Graber | | | 11-2-67 8 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Bolton Hill Nursing Home
90 | | | A. STATE Maryland
B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location)
3107 Kentucky Ave. | | |
| 5. SEX
Male | 6. RACE
Caucasian | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
1-18-98 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Millwright Ret. | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Adam Graber | | | 14. MOTHER'S MAIDEN NAME
Amie Hemler | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WWI | | | 16. SOCIAL SECURITY NO.
215-07-9470 | | 17. INFORMANT ADDRESS
Helen Graber, 3107 Kentucky Ave. |
| 18. 743X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Antecedent Causes
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) Cerebral Accident
DUE TO
(B) Hypertension A.C.V.D.
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
1 mo.
10 yrs.
2 da. |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pneumonitis | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
- | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
- | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
- | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
- | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 19 1965 to Nov. 2 1967 , that (I) (we) last saw the deceased alive on Nov. 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J. Duer Moore | | | | 23B. DATE SIGNED
11-3-67 | |
| 23C. PHYSICIAN'S NAME (Type)
J. DUEVER MOORES | | 23D. ADDRESS
3105 BELAIR RD. 71213 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
11-6-67 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore National | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. DATE REC'D BY HEALTH DEPT.
NOV 3 1967 | | | |
| 24F. NAME OF REGISTRAR
Robert E. Fairbanks | | 24G. FUNERAL DIRECTOR ADDRESS
Leonard J. Ruck, Inc., 5305 Harford Rd. | | | |

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